Approaches to counter loneliness and social isolation


Abstract
Social isolation and loneliness are significant threats for older people and may be associated with mental and physical health problems. This article revisits what is meant by social isolation and loneliness and explores the way in which social change can trigger both problems. Social networks are discussed as the means by which older people can mediate the stresses of change around them.

The article summarises some of the health consequences of loneliness, indicates some simple measures nurses can use to limit the risk of institutional loneliness and then examines how collaborative community ventures, mentoring and befriending schemes can help older people to access and rebuild social networks that may assist them to sustain wellbeing. Case study material is used to highlight contrasting profiles of older people who may be either more or less at risk of social isolation.

Aims and intended learning outcomes
The aim of this article is to assist you to take stock of loneliness and social isolation in older people, evaluating what nurses can do to help counter the risks to physical and mental health that they can bring.

After reading the article and completing the time out activities, you should be able to:
■ Discuss social isolation and loneliness in modern day society and the changes under way there.
■ Outline why social networks are critical in reducing the risk that older people will become socially isolated and lonely.
■ Summarise some of the possible sequelae of loneliness for older people, which have significance for nurses.
■ Outline simple support measures that can help counter institutional loneliness in patients.
■ Critically examine some of the initiatives used to help counter loneliness, identifying websites that patients, relatives and professionals might turn to.

Introduction
Loneliness has been described as a silent epidemic among older people, especially those in their eighties and nineties (Skingley 2013, Wood 2013). It is associated with a range of morbidities, but most significantly depression and higher levels of suicide (Houtjes et al 2014). Loneliness is not simply unpleasant and undignified, some older people die as a result of it. Loneliness is linked with deficits in self-care and motivation, and shortfalls in nutrition, exercise and personal hygiene: ‘If I have no one to care for, and no one to care about me, then what does it matter if I don’t look after myself?’ Hope for the future, self-worth and respect for social roles as older adults are all sapped by loneliness (Mezuk et al 2014). Authors describe how social isolation may prompt loneliness among older people who live alone but also those who live in institutional settings. An older person can be lonely in a crowd (Kvaal et al 2014). What is problematic for nurses, however, is finding a way to conceptualise this problem and determine what they can do to help older people minimise the risks that they will feel lonely. The work that nurses will then do is usually multidisciplinary, attending more closely to patients’ psychological wellbeing in institutional care settings, but also referring patients to community-based initiatives where older people are befriended. It includes a comprehensive assessment of the older person and the ways in which physical and psychosocial challenges interact to cause problems, those that nurses and colleagues must address (Martin 2010). Nurses’ work is built on a partnership with older people to review their situation and measures that will solve problems; a partnership in which patients should engage with enthusiasm.
Modern society
The concept of social isolation and the ways in which loneliness might arise from it have received less attention than they might. We live in a society where it has often been normal to live alone, where social networking may be conducted at a distance and via electronic means. We live in a changing society where social networks for the young as well as older people are not as tight as they once were. So understanding how circumstances coalesce to trigger loneliness as someone ages is important.

The issue of wondering what in practical terms nurses can do to alleviate loneliness is also problematic. Nurses might not think that they can make a difference. We are accustomed to working one to one with patients and there is limited time for their psychosocial care. The solutions are usually collaborative and they can seem once removed from what nurses do and where they work (Feyerer et al 2013). However, the case is made here that simple measures in institutional care settings can form the basis for longer-term work that supports patients.

In this article attention focuses first on the definitions of social isolation and loneliness and how they might be related. Berkman et al’s (2000) model of the function of social networks is used to help explore the relationship between social change and social isolation. Next, attention shifts to why loneliness matters for older people and why the imperative to identify loneliness and try to counter it are so pressing. Using two case studies you are assisted to take stock of what you know and what you do locally to recognise patients who are at risk of loneliness. Suggestions are made for simple social care measures in the clinical setting that will help patients to feel better supported. Assessing care needs in this setting starts from a comprehensive review of not only the physical problems that a patient presents with, but also the psychosocial challenges; see ocw.tufts.edu/data/42/499797.pdf for a useful download on comprehensive geriatric assessment (CGA).

Finally, the article helps you to review three strategic responses to loneliness, community action projects of different kinds, mentoring or coaching the lonely person and befriending schemes. Referral to such schemes may be part of nursing work as the patient is readied for discharge from hospital. To help you take stock of these initiatives a time out activity directs you to a number of websites where you can read about support measures.

Definitions
Dury (2014) defined social isolation as a circumstance where ‘an individual lacks a sense of belonging, social engagement and quality relationships with others’. Loneliness is defined as emotional isolation and is described as ‘subjective but involving feelings of lost companionship’. What links the two is the potential for social change, the way that people live, to have a profound effect on the health of older individuals. The World Health Organization (WHO) (2011) highlighted how powerfully and quickly socioeconomic conditions can shape wellbeing. Housing, patterns of work, communication, cultural institutions and norms are profoundly influenced by the distribution of wealth and other resources. Healthcare services are urged to redeploy their resources to promoting health and reducing inequalities, and to facilitate shared decision making in policy development.

Berkman et al (2000) developed a model designed to explain the relationship between the ways in which people live socially and how this affects personal health and wellbeing. They argued that social networks mediate the negative effect of social change. Social networks, groups that have a shared interest, that facilitate friendship and emotional support are more or less complex and rich and more or less densely arranged. A social network that operates locally for instance and binds people of many age groups, across different activities such as work and social life and which is founded in long-standing traditions – we might think of social networks in past mining communities, for example – is likely to support individuals well. It is likely to affirm self-worth, especially to older people as they pass down wisdom, play support roles with children and continue as valuable companions in the places where the community meet.

Looser social networks are those that meet sporadically, which focus on a single or limited range of activities and which may have limited scope for face-to-face meetings. Friendships on an online social network such as Facebook might constitute such a network. While networks set up on social media can seem superficial – people may for instance have hundreds of Facebook ‘friends’ who are no more than acquaintances – there is no reason why older people cannot use social media in their own way, featuring smaller friendship circles who discuss common experiences and who highlight ways in which problems can be solved. There is no single formula for social network use. ‘Local’ in an electronic communications age is a relative term. A community might be geographically dispersed but share a range of common interests and skills.

Now do time out 1.

For Berkman and colleagues (2000), the fact that modern society is increasingly characterised by looser social support networks, was problematic. Such networks are less well equipped to mediate the negative experiences of social change for individuals. We may have more but rather superficial friendships.
1 Social networks

Berkman et al (2000) described social networks as having several roles. These include support in times of adversity, influence (affecting the behaviour of members but also helping the group to influence outsiders), securing resources that individuals need and influence on lifestyle that affects health (for instance, determining whether cigarette smoking seems acceptable). Think now about your own social networks. Are these rich, local and complex or are they looser in form? Do they fulfil the sort of social roles that are discussed here?

The coherence and cohesion of social support networks are weaker and associated with the social mobility of individuals, how and where people live and work. Extended families who once lived in one village may now live across the country or in several different countries. The argument then runs that older people, who are more reliant on social support networks as they age, deal with illnesses, housing and other problems, are disadvantaged and a growing range of physical difficulties, especially those related to the senses or mobility, are disadvantaged when networking is more superficial and dissipated. The fast pace of social change makes it more difficult for older people to claim that their experience is valuable to the younger generation. It is tempting then to feel that in old age the individual is a burden rather than an asset to those social networks that do exist.

Now do time out 2.

2 Case studies

Turn now to the case studies of Mr Donald and Mrs Crow, which are presented in Box 1. The case studies contrast in terms of the quality of social networks available and the challenges faced. Study each person’s life story and decide whether they might struggle to secure what they need to feel a sense of belonging and to ward off loneliness. In your experience how characterise these older people of patients that you care for?

While in principle older people are more vulnerable to social isolation and a creeping sense of loneliness, it is by no means a universal experience. Well-educated, well-organised and articulate older people are better equipped to build and sustain social networks. They may, for instance, form groups based on cultural interests such as art, reading, theatre and cookery. Pensioners with a significant retirement income are better equipped to travel in order to maintain social contacts with others.

Significantly, older people can and do exercise choices about their level of social engagement. An older person who has tended to an introvert lifestyle in younger years and who prefers to limit the range and number of friendships may still remain content to live that way in older age. As one patient told me: ‘Radio 4 is my friend and The Archers [a radio drama series] and that has seemed quite enough.’ More gregarious individuals may be at greater risk of social isolation and loneliness if they experience sudden loss of loved ones or significant curtailment in their mobility. What is at issue is the degree of change experienced from the past lifestyle norm. Where this is significant and sudden, distress may be expected.

Other groups of older people more at risk are those with chronic illnesses that undermine their energy and morale, those with poor incomes, those who in previous years have had mental health problems, especially depression and those who for practical reasons are moved from their homes.

Box 1 Case studies: Mr Donald and Mrs Crow

Mr Donald is a retired schoolteacher, aged 83, who lives alone in a small terraced house on the edge of town. Most people have lived in this street all of their lives, he tells you. He claims that he can name all but one of the ten neighbours who live at his end of the terrace. His daughter lives in Birmingham, which is 150 miles away. He lost his wife to a heart attack ten years ago but tries to keep himself busy by visiting the library once a week, swimming on a Tuesday and attending a book club on Friday evenings. For the past 18 years Mr Donald has been managing diabetes mellitus, taking tablets and doing his best to control the level of sugar in his diet. He does, however, also have rheumatoid arthritis and that limits his dexterity.

He has a good deal of pain in the morning from his arthritis and sometimes that is at issue is the degree of change experienced from the past lifestyle norm. Where this is significant and sudden, distress may be expected. He admits that there are days when he has not left the house.

When you ask Mr Donald about what sort of life he has led he tells you that it has been quiet. As he puts it, ‘you have to be enough to yourself…we all die alone you now, so there is no point in not liking your own company’. He laughs at his own joke and describes himself as stoical in nature. ‘You have to be that way when you have taught so many kids and watched some of them grow up well and others go off the rails. Teaching teaches you personal discipline. You can’t set a bad example to children and you don’t change those disciplined habits when you grow older either.’

Mrs Crow is 78 and lives in a small council flat on the 11th floor with her 84-year-old husband, Stan, who had a stroke six months ago. Stan cannot speak clearly as a result of the stroke and he sometimes struggles to understand what has been said to him. His recovery from hemiplegia is incomplete and he can still be a little unstable on his feet. Mrs Crow has applied to be rehoused again to a ground-floor property. She is determined to cope with Stan’s care, but admits that their only immediate neighbours are the pigeons on the balcony. Her friends, of whom she has several, remained in another part of town when she was rehoused three years ago. Neither Mrs Crow nor her husband has much income, relying on the state pension. She spends much of the time with the television for company, although the daytime fare of gossip shows and loan adverts is depressing. She would describe herself as being in good health, but it is frustrating only getting out once a week to do some shopping while a social work volunteer – one of many, they keep changing – comes to sit with her husband.
a familiar environment to a new one. For example, Kvaal et al. (2014) reported a high degree of social isolation and loneliness among older people in a Scandinavian hospital; 75% of patients reported this problem. Berkman et al.'s (2000) model would encourage nurses to anticipate such statistics as familiar social networks are disrupted.

What is most significant about Berkman et al.'s (2000) model, however, is the posited explanation of how ‘upstream’ influences such as the social determinants reported by the WHO (2011) represent threats to individuals’ wellbeing (see Figure 1). Berkman et al. (2000) argued that social structural conditions such as changes in politics, culture and communications systems accrue to form an experience of social change. These changes are more or less successfully mediated by social networks.

Well-organised social networks can protect the older person from the worst challenges of upstream change by mediating discomfort through the social roles that they fulfil. Where networks work well, for example, in providing friendship, solace in loss and reassurance of self-worth and esteem, there is considerably less work for healthcare professionals to do. People, for example, who are well supported in taking exercise, eating a balanced and nutritious diet and remaining stimulated despite a cold and dark winter, are much less likely to develop deficits of the kind summarised in the outcome pathways box in Figure 1.

Now do time out 3.

3 Social structural changes

Pause now to think of the social structural changes that your local community has experienced in the past ten years and how this may have shaped the lives of older people that you care for. For example, where are older people living now and what opportunities exist for them to travel and to meet friends or family? What is public transport like where you live and work? How have working lives changed and how does this seem to affect family efforts to sustain support for older people? Are older people countering these changes by making use of social media to form new ways of communicating with one another?

The effect of loneliness

Sintonen and Pehkonen (2014) confirmed that rich and well-organised social support networks can insulate individuals against feelings of loneliness. In a survey of 1,680 individuals aged 55-79, the value of social support was clear; individuals living in effective social support networks felt secure. However, a growing number of factors can increase social isolation and loneliness in older people. These include:

- Enforced change in living arrangements. Kvaal et al. (2014) reminded us that people with and without others around them can feel lonely. To move into a nursing home, for example, disrupts social contacts as well as offering new ones.
- Sudden loss of significant others, especially a spouse or partner. This loss can be challenging, especially for individuals who have lived a lifestyle different to the statistical norm in society. So older gay men and women might face difficulties as they search for new support.
- Gregarious people who through illness or injury face a sudden curtailment of their ability to socialise in preferred ways. A patient who has a stroke is a good example of this, especially if speech and/or mood are impaired as a result. The narratives of the 101 patients that Kvaal et al. (2014) interviewed describe the experience of loneliness. These respondents described loneliness as 'strange', 'ugly', 'wrong' and 'shameful'. Each of these descriptions bears brief scrutiny. To feel strange is disconcerting for older people, many of whom have lived through years of war and economic constraint where to co-operate and strive together was the essence of what it is to be human. An ageing body may mean that older people already feel ugly, but the feeling of social ugliness and limited social worth is more disturbing still. Loneliness feels wrong when the individual believes that human beings are meant to be sociable. Emotional isolation may be profoundly felt in strong contrast to the camaraderie of work, when each individual had a clear social role in the team. Shamefulness may be felt as people review what they think they should have been able to do to counter emotional isolation: 'I should have pulled myself out of this and I didn’t.’ To be lonely may be equated with unworthiness, looking, acting and thinking in ways that make it much harder for others to approach you. This experience is profound when the older person is dying. Then he or she suffers an existential loneliness. Others cannot relate to me, they cannot love or feel for me, because they will live and I will not (Browall et al. 2014).

In practice, loneliness and feelings of social unworthiness can become self-fulfilling prophecies. As older people start to doubt that they are any longer worthy of social discourse, so they find it harder to concentrate and think in ways that are social, which help them to relate to others. Reasoning itself is conceived in social terms, formulating accounts, experiences, ways of resolving problems, in a manner that we believe others will feel empathetic towards. Lonely individuals can lose the knack of reasoning in ways that make them seem attractive to others. Jaremka et al. (2014a) reported how
loneliness and cognitive problems correlate in cancer survivors. People learn to memorise things in a social way, to link significant events to people and people to self-worth. When this link is broken, when older people feel alone with their diagnosis, then their ability to relate comfortably to others can be impaired. Jaremka et al (2014b) suggested that in extremis, patients can benefit from omega 3 supplements that help to boost memory and social reasoning. A good diet and self-care are fundamental to self-esteem and sustaining a readiness to engage with others and to counter loneliness.

Now do time out 4.

Writing about the work of nursing, the theorist Dorothea Orem emphasised that it is the role of nurses to build a sense of self-efficacy in patients. Nurses help patients realise what they can control and do for themselves (Renpenning and Taylor 2003). A problem arises when we consider patients who are lonely, however, and who are already struggling to self-care. Maintaining medication regimens, looking after hygiene, dealing with wounds, stomas and prosthetics may be much more difficult when patients ask, ‘Why am I bothering?’ or ‘Who is this all for?’ The volition to persevere with self-care measures is often referenced against a wish to please or impress those who are dear to patients. The motivation is extrinsic and social, rather than intrinsic and personal. No matter what nurses commend patients should do, because of health maintenance or recovery, progress for lonely patients may be slow, negligible or absent. Understanding what or who motivates patients is then important.

In extremis, failed hope, a lost belief that progress can be made, that goals can be reached, becomes depression. If there is no one to impress, no one to stay well for, then self-belief falters. Writing about depression Houltjes et al (2014) noted how in the community depression was more common and more recalcitrant to treatment when patients had a smaller social network, or one less active. Their longitudinal study was the more powerful because it followed patient experiences over 13 years.

Kim (2014), researching older adults who had made a failed suicide attempt in Korea, found loneliness no less influential. Where there were no others to relate to,
life after failed suicide was one with no escape because they did not 'even have the luck of dying'. To live after failed suicide without social discourse, without meaningful support meant additional hardships associated with suicide attempt sequelae, for example, greater sadness, a deepening dependency on tranquilisers and a 'seesawing between despair and faint hope'.

Sprinks (2014) reported that while there had been a reduction in the number of suicides among older people in the UK, for example, in 2012, 270 men aged over 75 compared with 304 in 1981, the level of suicides and suicidal thoughts remained high among older men especially. In long-term care facilities for older people, Mezuk et al (2014) observed that as many as one third of residents had contemplated suicide in the past month. The authors correlated such thinking with lower staffing levels and, by implication, limited amounts of social discourse. Yet talking in a strategic, empathetic and supportive manner can help. Forsythe and Forsythe (2014) described how the development of supportive talking, for example, exhibiting a genuine regard for the patient's experience and perspectives on health and related matters, can materially improve self-esteem and self-efficacy.

The effect of loneliness on the health of older people cannot be overestimated. Loneliness affects the experience of illness, treatment and care and the experience of care settings. Patients' ability to derive the most from the facilities that nurses offer is influenced by the extent to which they feel that they belong and are respected as valuable members of the social network that exists there. Failure to attend to loneliness may delay progress to self-care and make healthcare treatment of chronic illness in the older population lengthier and more expensive. Failure to attend to loneliness among older people may mean growing levels of depression and suicidal thinking. Those older people who already have mental health problems, for example, excess levels of anxiety, may find that their problems are exacerbated by loneliness (Barton et al 2014).

Strategies to counter loneliness
At a personal practice level some simple measures can significantly reduce the risk that patients feel lonely in institutional care settings. It is there that patients formulate two impressions; first about what nurses wish to help them with; and second, what nurses expect of them. A comprehensive assessment signals to patients that nurses’ interest is not simply in wounds, treatments and physical rehabilitation. Care is social and psychological in nature too, attending to how an illness, injury or disability feels. While nurses need to remain mindful of confidentiality, there is merit in encouraging patients to share experiences with one another where that seems comforting. My own experience of educating nurses in association with the Royal Hospital Chelsea affirms this. In that setting Chelsea pensioners were ‘old comrades’ because of their shared background in the British army. But comradeship extended to discussing best ways to combat problems of ageing and how best to make sense of loss when another pensioner died.

Important care measures include:
- Taking fuller nursing histories and paying attention to social events and their possible effect on patients and their existing social contacts. It is important to understand from patients who their perceived social support network is and whether illness seems to disrupt that. CGA begins with an understanding of the problems that patients present with but moves on to understand the interplay of psychological and social circumstances that affect their experience of a problem and their ideas about what a solution might be (Martin 2010).
- Conveying to patients how legitimate it is to express a sense of loss, anxiety or doubt associated with their social position, the need to belong and relate their experiences to others.
- Seizing conversation opportunities to learn about patients as people with their own history that shapes how they experience social as well as health change.
- Asking nurses from a similar cultural or social background to work with patients wherever possible. Rapport is likely to be easiest when nurse and patient have much in common from the outset.
- Making care records that attend to patients’ emotional state, so that colleagues can better judge when they might start to feel isolated.
- Introducing patients to others in their immediate vicinity and identifying what they may have in common: ‘This is Mrs Jones, she tells me that she comes from Reading, too.’
- Encouraging patients to narrate their illness experiences and the ways that they combat these. Coping narratives help patients to form social bonds. Friendships formed in hospital may be sustained in the community later.

In many institutional settings care encounters between nurses and older patients may sometimes be short, so it is important to consider larger and more collaborative initiatives that might support older people in the longer term. It is to those that we now turn. Charities supporting older people have led the way in many of the initiatives that follow, and much of the work is done with volunteers. It is important for nurses to be aware of these initiatives so that patients and/or their relatives can be acquainted with what might be possible to support them over time.

Three types of initiative are outlined and each works on slightly different premises. Collaborative community ventures are designed to build and sustain
the support networks that may have been lost as social change has eroded older people’s opportunities to relate to others (Bartlett et al 2013). The ventures are designed to create opportunities for people to meet and, quite often, to share a meal together or to engage in healthy activities such as exercise (Feyerer et al 2013). The second initiative is aimed more at patients with a healthcare deficit and is designed to get them to the point where they can rejoin existing social support networks. Mentorship is used to help patients develop self-belief in what they can do and how they can relate again to others, even if they have a disability, illness or injury (Bakhshi and While 2014). The third initiative is designed to extend longer than mentoring and aims to offer sustainable friendships to older people over the months or years ahead. As well as having a social network older people need a few close and sustained friendships, so volunteers are matched to clients by background or interest and encouraged to build authentic friendships that remind older people of their value to others (Lester et al 2012).

Now do time out 5.

5 Support initiatives

Explore each of the following websites now to decide what support initiative is proposed and how it conceives of help and the social network. Are any of these initiatives of a particular kind, for example, community building, mentoring or befriending in approach?
- www.contact-the-elderly.org.uk
- www.ageuk.org.uk (note: Age UK provide a variety of services but attention is drawn in particular to their befriending work designed to combat isolation)
- www.thesilverline.org.uk
- www.carenetproject.eu (as much networking and support is provided online today, this initiative is important and challenges nurses to consider what older people can master in new technology)

Collaborative community ventures The principal goal of collaborative community ventures is the better co-ordination of a range of different and discrete services to older people, so that support is experienced as a whole. So, for example, day centres, lunch clubs and those services designed to help older people to travel, shop or visit need to be co-ordinated. Stewart et al (2014) argued that care support services are too often experienced as a disparate collection of facilities and that there is benefit in bringing these together, preferably through the services of key workers who help older people to access the right type of support. Well co-ordinated services are experienced in much more social network terms, they appeal as being better joined up in their support provision.

Bartlett et al (2013) reviewed three collaborative community ventures in Queensland, Australia. The first, Seniors Connecting, was designed to promote fitness among older people, to build transport facilities associated with that and to help them organise their own activities. The second, Connecting Points, focused on the development of buddy systems, the use of forums for older people and the development of a volunteer workforce. The third, Culturally Appropriate Volunteer Services, centre its work with older migrants to Australia, the training of volunteers and the development of leisure and library resources. While each of the projects had a slightly different foci, all had in common the better co-ordination of facilities and the building of social networks.

Bartlett et al (2013) reported the complexity of measuring the effect of such disparate support activities on the wellbeing of individuals. They expressed caution about measurement in areas such as this. However, they concluded that the projects evaluated did have a positive effect on older people and the alleviation of social isolation that they might otherwise have felt. The active engagement of older people in the organisation and running of activities, as well as service recipients, materially insulated them against feelings of loneliness.

Now do time out 6.

6 Funding

One of the problems for collaborative community ventures is that they often depend on different funding streams. In times of austerity, projects can falter because one or more source of income is compromised. Think now about any local initiative that you are aware of. How secure is this project’s funding? Have you or other nurses expressed support for such projects, explaining how they can materially improve the health as well as the social wellbeing of older people? Think now about to whom you might make your case should one need to be made.

Mentoring schemes Mentorship schemes are founded on the premise that people can develop personal confidence to return to and contribute to social networks if they are taught relevant skills as they recover from a health problem. Mentoring assumes that a more skilful and confident adviser – the mentor – can guide, assist and to varying degrees teach the individual to act in ways that
facilitate independence. It is assumed that individuals need to learn how to take the initiative for themselves, approaching those who might be able to support them over the longer term.

Bakhshi and While (2014) explained that mentoring is one part of a response that can be used to assist older people who are drinking excess amounts of alcohol. Importantly, what is required is not only that volunteers are trained in mentorship skills, for example, the supportive re-evaluation of lifestyle and choices, but that the mentor works with an appropriate counselling framework. Mentors may come from many walks of life and not all are from health professional backgrounds, but they need to operate in a professional manner, respecting the rights of older people and their privacy. To mentor is to facilitate, encourage and support.

You might find mentoring schemes linked to care programmes in hospitals, those that pick up the support of patients once they have gone home. Mentorship may be especially important in chronic illness conditions where the older person has to manage their condition and to represent it in social networks that they rejoin. So, for example, mentorship is valuable in alcohol addiction, when patients have to explain their altered diet as in diabetes mellitus, and when patients have a potentially stigmatising health problem to relate to intimate others, for example, if they are HIV positive. Knowing when to conclude the support arrangement can be problematic in mentorship programmes. Mentors work to make their contribution unnecessary, but some older people might become dependent on the friendship that they appear to offer.

Now do time out 7.

Befriending schemes The most popular and widespread approach to help older people avoid social isolation and fend off loneliness is arguably befriending. Your enquiries associated with time out 5 should have acquainted you with variants on this approach. Friends are trained individuals who express and demonstrate a sustained and sincere interest in older people as individuals and who work to enable them to build their self-esteem and in turn contribute to the wellbeing of their peers. Friendship may be offered face to face, by telephone or online.

Lester et al (2012) emphasised that befriending relies on volunteers being able to develop a safe and confiding relationship with older people. The friendship may be designed to last over protracted periods of time and for that reason it is critical that volunteers are vetted and that their work is monitored. Volunteers become trusted confidants of older people and the support relationship could be open to abuse if it is not well managed. They should have good conversation skills, an empathetic nature and the confidence to broaden the interests of the older person supported. If the friendship focuses solely on the memories and experiences of the older person, encouraging them to look inwards, opportunities to develop interest in others around them will be lost.

Telephone befriending schemes may have particular appeal (Wilcox 2014). Not only can they offer a 24-hour service, so that loneliness can be combated just in time, but they limit the logistical costs of visiting the older person. More older people may be served by regular telephone calls at pre-agreed times than might be supported by visitors who must travel to see them. Against this, however, it is important to link such a telephone service to others who may visit, community-based nurses for instance. By telephone,
volunteer friends cannot make an assessment of whether older people are caring for themselves well. Telephone befriending necessarily relies on self-report measures.

Volunteer friends need to have careful regard for their working relationship with family members as well. While many befriending services are targeted at older people who have no living relatives, others may have to link with families who are able to make periodic visits. In these instances one social network supports the other. If such a befriending service appears to compete with family supporters, conflicts of interest can arise.

Now do time out 8.

8 Volunteer friends

Decide now what you would say a volunteer friend might offer to an older person, which you might share with a patient or their relatives. If you have any positive experiences of such a service in the past, jot these down so that you can illustrate what can be achieved. You will need to preserve the anonymity of past patients well served, but types of supportive help can and should be characterised.

Conclusion

The aim of this article has been to facilitate your understanding of social isolation and loneliness, to understand how these arise and why loneliness needs urgent attention. It has set out some of the personal practice measures that you can use to counter institutional loneliness and then moved on to consider more collective and strategic services that are provided, often through charities and the assistance of volunteers.

While loneliness and social isolation can seem daunting and complex problems, we can understand them better if we consider the part that social networks play in the wellbeing of individuals. Social isolation and loneliness are much more likely where older people do not have access to a well-developed and cogent social network, or under circumstances where they are less able to interact in that network. Social change, which might move apace, severely tests older people and especially if social networks have been disrupted in some way.

The case studies of Mr Donald and Mrs Crow highlight the significant differences in the circumstances of older people. While Mr Donald lives alone he is much better prepared to cope with social isolation and has taken steps to sustain and build friendships. He has a sense of community in his street. Mrs Crow, who has the company of her husband, is however, much more poorly placed to cope with her sense of isolation. She is likely to feel trapped with a husband whom she loves, but who cannot provide the company that she may have been used to.

While the primary work of nurses is usually reactive, dealing with the illness, injury or disability sequelae of the ways in which people live and change circumstances affecting them, they can conceptualise the problem before them using social network theory and make a case for intervening upstream to others. At the most practical and immediate level, they can and should explain to patients and relatives what support schemes are available, those that might materially support older people’s mental health and sense of wellbeing.

Now do time out 9.

9 Reflective account

Now that you have read the article you might like to write a reflective account. Guidelines to help you are on page 40.


