Loneliness

Easing the Pain of the Hospitalized Elderly

By Beth L. Rodgers, PhD, RN

The topic of loneliness has recently become an area of focused inquiry, yet it is an area of considerable significance in the nursing care of the older adult. It is, as Ryan and Patterson indicated, a "psychological phenomenon having powerful implications for mental health and illness." When a lonely person is unassisted or the loneliness is unresolved, the individual may experience a decreased ability to function, self-isolation, and ultimately a diminished sense of self-esteem. The result may be a perpetuation of dependence and declining physical and mental health, which often accompany such stressful circumstances and may already pose severe threats to the functioning of the older adult.

Loneliness has been hypothesized as affecting the older adult and the elderly with particular frequency, primarily because of life events that contribute to its development. With admission to a hospital, experiences of loneliness can be intensified easily as the individual is separated from persons or things to which he or she attaches meaning or significance. In addition, medical or other therapeutic regimes may also induce or exacerbate loneliness as they cause disruptions in familiar patterns of activity and interaction.

In this article, the incidence of loneliness in a group of older adults hospitalized on a medical unit in an urban acute care facility is explored, resulting in the identification of guidelines for nursing practice and for further research in this area.

DEFINITIONS AND RESEARCH CONCERNING LONELINESS

Although loneliness has been defined in a number of ways in the literature, there is general consistency in the approach to this phenomenon. The work of Peplau, which is based on the interpersonal approach of Sullivan, has provided a foundation for views of loneliness that have evolved in nursing. Peplau described loneliness as an extremely unpleasant experience, "so dreaded and so painful that it must be disguised." Francis emphasized the tremendously unpleasant nature of this experience, defining this subjective state as "a vague, dysphoric, reactive response to the more or less temporary separation from persons and things one has endowed with meaning, import, and energy..." This act of attaching significance to important persons and objects is referred to by Francis as cathetic investment, from the Greek term kathexis, meaning "holding.

Loneliness in the latter instance refers to what Francis described as secondary loneliness, a phenomenon experienced as the result of temporary separation from persons or objects that the individual has invested with meaning or energy. In contrast, primary loneliness is regarded as a universal human characteristic and is sometimes referred to as existential or cosmic loneliness. It is the "natural result of being an individual organism with conscious awareness of that singular state." According to Francis, "one must be separated from loved persons and things before one can, if in fact he [or she] does, experience secondary loneliness." 7

Loneliness, therefore, is not strictly an individual phenomenon; rather, it is a social one because of its reference to the reciprocal relations of interacting human beings. Numerous factors have been identified as contributing to the incidence of loneliness and have included widowhood, the availability of transportation, the frequency of visitors and phone calls, and being female. Additional correlates of loneliness have been identified as physical incapacity, perception of poor health, perception of dependence, relocation, role change, pain, and the loss of a pet. 2,4,9

Completed research in nursing concerning loneliness is limited, although
significant contributions have been made by Francis and Francis and Odell. Six empirical investigations were conducted by these researchers with sample and age groups including medical patients (x age = 54), city jail inmates (x age = 26), residents of a home for the aged (x age = 82), and patients in a private nursing home (x age = 75). Using the Schedules for the Measurement of Loneliness and Cathetic Investment (SMLC), which allows for possible loneliness scores ranging from not at all lonely (5) to very lonely (25), residents of the home for the aged responded with a mean loneliness score of 11, indicating that they were only moderately lonely (Figure).

In previous studies, hospitalized adults scored slightly higher (x = 14), while jail inmates averaged the highest score in these studies (x = 18). In the group that lived in a residential home for the aged, 29% of the subjects replied that they had not experienced loneliness; 24% indicated that they would have been lonely had it not been for visitors, friendships, mail, and other factors. Only 4 individuals said that they had experienced loneliness while living at the residence.

As the authors indicated, situational factors, such as the physical surroundings of the subjects and opportunities for social interaction, may have had a significant effect on the individuals’ feelings of loneliness. In another study, Odell found that of 55 adults who were hospitalized on medical and surgical units and were screened using the SMLC, 51% were found to be lonely. Data regarding the ages of these subjects were not reported for this particular study, however.

Despite these efforts, there has been minimal research concerning loneliness in hospitalized adults, and age has not been evaluated as an independent variable. Consequently, reports of completed research raise numerous questions regarding the magnitude and incidence of loneliness in the hospitalized older adult and situational factors affecting its occurrence. In addition, the changing character of hospitalized patients, specifically a trend toward higher acuity and an average older age of inpatients, indicates the need for additional research concerning loneliness in this population.

METHOD AND CONCEPTUAL FRAMEWORK

This study explored the incidence of loneliness and related factors in a sample of adults age 55 and older and hospitalized on a medical/family practice unit of a large, urban midwestern acute care facility. Subjects were selected from the inpatient population who were 55 or older, hospitalized for two days or more with the current admission, English speaking, and medically competent to give their informed consent to participate in the study. All persons meeting these criteria were approached to participate in the study and a sample of 31 individuals was selected. Data were collected on an interview basis using the SMLC and were analyzed using parametric and nonparametric statistics, along with qualitative methods for the analysis of responses to open-ended items.

The SMLC is based on a conceptual framework concerning emotional investment, separation, and resulting secondary loneliness. As Francis indicates, individuals endow certain significant persons and objects with energy and importance. In the course of life, periods of separation occur whereby the individual is unable to maintain proximity to some, or occasionally all, of these objects. The greater the cathetic investment made in the social or physical objects, the greater the deprivation when separated and the greater the resulting loneliness.

The 16-item instrument is divided into two sections. The first contains five scaled items designed to evaluate the
### FIGURE
**SCHEDULES FOR THE MEASUREMENT OF LONELINESS AND CATHECTIC INVESTMENT**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. First, about where you lived when you came to the hospital . . . was it a:</td>
<td>House 5</td>
<td>Apartment 4</td>
</tr>
<tr>
<td>2. About how much time would you say you spent there:</td>
<td>Practically all 5</td>
<td>Most time 4</td>
</tr>
<tr>
<td>3. How many people lived with you?</td>
<td>More than three 5</td>
<td>Three 4</td>
</tr>
<tr>
<td>4. What relations were they to you?</td>
<td>Spouse 4</td>
<td>In-laws 3</td>
</tr>
<tr>
<td>5. With how many persons, generally, would you say you were closely attached or emotionally close when you came here?</td>
<td>More than three 5</td>
<td>Three 4</td>
</tr>
<tr>
<td>6. Did you have any special things, other than people, where you lived that were and are particularly important or meaningful to you?</td>
<td>Many 5</td>
<td>A few 4</td>
</tr>
<tr>
<td>7. What are the things or objects that were and still are particularly important to you?</td>
<td>Certain foods 5</td>
<td>News/Phone/Mail 4</td>
</tr>
<tr>
<td>8. Some people miss their homes when they have to leave. Do you miss or feel particularly separated from where you lived since you came to the hospital?</td>
<td>Most of the time 5</td>
<td>Sort of 4</td>
</tr>
<tr>
<td>9. Do you miss or feel separated from any of the persons you said you were close to?</td>
<td>Most of the time 5</td>
<td>Sort of 4</td>
</tr>
<tr>
<td>10. Do these persons visit you here?</td>
<td>Never 5</td>
<td>Rarely 4</td>
</tr>
<tr>
<td>11. Do you particularly miss or feel separated from the special things you mentioned (rename them)?</td>
<td>Most of the time 5</td>
<td>Sort of 4</td>
</tr>
<tr>
<td>12. Try to describe what it has been like to you, or how it feels to you, to be separated from the people and things you were and are used to being with?</td>
<td>Much more 5</td>
<td>Some more; 4</td>
</tr>
<tr>
<td>13. Do you miss the people (rename them) and things (rename them) more or less the longer you are here in the hospital?</td>
<td>More except 5</td>
<td>Some more; 4</td>
</tr>
<tr>
<td>14. (If No. 13 rated 5 or 4) can you say why you miss them more the longer you are here; why it gets worse?</td>
<td>Unable to say;</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>15. When will you be discharged?</td>
<td>Give a date.</td>
<td></td>
</tr>
<tr>
<td>16. Would you say you experienced loneliness while you have been here in the hospital?</td>
<td>Yes but it was broken up by . . . 5</td>
<td>Unable to say;</td>
</tr>
</tbody>
</table>

degree of cathetic investment and five others that assess the degree of separa-
tion from these persons or objects. A final item calls for respondents to identify whether or not, and to what extent, they have experienced loneliness while in the hospital and also allows for the evaluation of the content validity of the instrument. The remaining items are open-ended questions that elicit responses regarding the types of objects or the people to whom individuals are attached and their general perception of how they feel as a result of their current separation.7

The validity and reliability of the instrument have been repeatedly established.6-8,12 In several previous studies, Francis6 assessed the reliability using a test-retest procedure (r = .980, P < .001). Three earlier investigations, two with hospitalized individuals and one with persons living in a residential home for the aged, resulted in criterion-
related validity coefficients of r = 1.00, .64, and .45, respectively, all of which were statistically significant at the .05 level. Further evidence of the validity of the instrument can be obtained through statistical analysis of the correlation between the loneliness score and the individual’s self-report of loneliness, a technique that was employed in this study of hospitalized older adults.

FINDINGS
The sample of 31 subjects included 12 men and 19 women inpatients ranging in age from 55 to 87 years (x̄ = 67.5 years) who had been hospitalized for 2 to 21 days (x̄ = 6 days). Twenty-one of the subjects resided in a house, 8 lived in an apartment, and 2 were institutionalized in long-term care facilities. All of the men lived in a privately-owned house. Ten subjects (all women) lived alone, 10 resided with their spouse only, and 7 resided with the spouse and other persons.

Cathetic investment scores for this subject group ranged from 13 to 24 (possible scores 5 to 25), with a mean score of 17.78 (mode = 17), indicating a moderately high amount of investment. Loneliness scores were moderate and ranged from 4 to 23 (x̄ = 14.33, mode = 17). Pearson product-moment correlations performed for loneliness scores with the self-report of loneliness were statistically significant (r = .4701, P = .004), providing support for the content validity of the instrument.

Regarding the self-report of loneliness, it is important to note the actual responses to this item. For the question, “Would you say you have experienced loneliness while you have been here in the hospital?,” it is significant that more than one third of the group (n = 11; 35%) indicated that they had experienced a high degree of loneliness. Interestingly, however, of the 10 subjects who lived alone only three rated their response toward the higher end of the 5-
point Likert scale.

Content analysis of open-ended response items revealed more information regarding the experiences of the subject group (Table). When asked to describe the things most important to them, active recreational activities were the most frequently cited (n = 13), followed by modes of entertainment, a more passive form of activity (n = 8). Pets (n = 5) and pictures (n = 4) were also mentioned with some frequency.

Despite the relatively moderate group scores on the loneliness scale, many subjects indicated that they did feel considerable distress as a result of the hospitalization experience and their separation from significant persons, things, and activities. More than one third of the subjects indicated that they missed others, their home, or activities (n = 11), while one third reported feeling “terrible,” “miserable,” “cooped up,” “lost,” or “guilty,” with their experience of separation being “difficult” or “rough.”

Eight individuals (26%) indicated that they had resigned themselves to the current hospitalization experience and that, although the separation was difficult, they recognized that their present situation was necessary. Although the terms “lonely” or “loneliness” do not appear anywhere in the instrument except for the last question, six subjects described their feelings about separation from significant people or things as being “lonely” or “lonesome.”

More than half of the individuals interviewed (n = 16) indicated that they missed significant persons or objects more the longer they were in the hospital, with the most frequently cited reason being that they missed the contact with and companionship of others (n = 11). Changes in activity and levels of stimulation were also cited (n = 5). Four subjects indicated that they missed catheted persons or objects less as time
passed, primarily because of their perceptions of the quality of the hospital care and their recognition of the importance of the hospitalization to their health status. The majority of subjects had significant persons visiting them in the hospital either every day (n = 19) or every other day (n = 5).

DISCUSSION
The relatively low mean incidence of loneliness in this subject group is in opposition to the usual expectations concerning the hospitalized older adult population. In this sample, several extraneous factors may have contributed to these scores. The high frequency of visitation experienced by some subjects may have prevented reaching the degree of separation necessary for loneliness to develop. As this particular agency tended to serve a community with a large proportion of first- and second-generation Americans, the cultural backgrounds of the subjects may have affected the extent of visitation experienced.

Findings regarding only a moderate amount of cathetic investment by the subjects may also be a significant factor concerning the development of loneliness. This amount of investment may be related to role changes that accompany aging, along with experiences associated with the loss of significant others and a decline in health. Because the living situation of the subjects did not indicate the degree of loneliness experienced, social networks, investment in pets and physical objects, and recreational or diversional activities may be considered in assessments as indicative of significant support factors.

As indicated by four subjects, the hospital may provide a sense of security for those who believe that they are being cared for competently and that hospitalization will lead to improved health. Such perceptions undoubtedly mitigate the adverse effects of hospitalization while the individual is an inpatient, yet may present considerable difficulties at discharge.

These findings have significant implications for nursing care, the first being the importance of attentive history taking and assessments. Assessment data including information regarding cultural background; identification of significant persons, objects and activities; and previous hospitalization experiences may provide important information for planning effective nursing care.

Visitation policies that allow frequent and meaningful contact with significant others are also essential in diminishing the effects of separation as a result of hospitalization. Similarly, encouraging the presence of catheted objects, such as pictures or items promoting maintenance of usual activities or modes of entertainment, may also contribute to lowering the incidence of loneliness for hospitalized individuals.

As Odell indicated, the presence of the nurse may offer considerable support to individuals who are experiencing separation and are consequently at risk for developing secondary loneliness. In addition, patients may benefit from information explaining and supporting the need for the current hospitalization and recognition that community services will be enlisted when needed to provide support after discharge.

The goal of promoting a familiar environment and facilitating a degree of control by individual patients is familiar in nursing care. As a result of this study, it is apparent that such a plan of care may decrease the incidence of loneliness in addition to other beneficial effects.

There is a need for improved means to evaluate the incidence of loneliness and the experience of hospitalization in the older adult population. Many subjects in this study reported feeling considerable distress as a result of being separated from significant persons, objects, and activities. However, such perceptions were not consistently referred to as loneliness by the subjects. Descriptive research to explore subjective phenomena for the older adult in association with hospitalization and separation from others is warranted. As a result, improved conceptualizations may be generated that better characterize these experiences and that identify appropriate interventions.

CONCLUSION
Loneliness is a highly variable phenomenon, yet it can be a potentially devastating experience for some individuals. It is believed to be perpetuated by an increase in health problems and by environmental changes, such as those associated with hospitalization, and changes in social support, personal control, and independent activity. Such experiences may significantly increase the stress of hospitalization. They may also result in an exacerbation of physical problems, anxiety, or other threats to mental health if undetected and if appropriate interventions are not instituted.

Nurses can play an important role in
alleviating the older adults' feelings of loneliness and in promoting the quality of the hospitalization experience. They can do this by being aware of precipitating factors and behavioral manifestations of loneliness and other forms of distress, assessing for the occurrence of such responses, and developing plans of care based on the anticipation of individual needs. 3-4,18

As the proportion of older adults in the general population continues to increase, such concerns take on even greater importance.16,19 Further research is needed to identify loneliness and related phenomena in the older adult and to promote the development of effective nursing care strategies.

REFERENCES

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1. For the older adult, loneliness may contribute to deterioration in physical and mental health.
2. Some factors that may contribute to loneliness in the older adult include the death of a spouse, loss of a pet, lack of visitors, physical incapacity, role changes, and relocation. In general, loneliness may be the result of events that typically occur as a part of the aging process.
3. Nurses can decrease the incidence of loneliness in the older adult by encouraging access to visitors and facilitating involvement in usual activities.
4. Assessment information that is needed to plan nursing care to decrease the incidence of loneliness includes data regarding the patient's cultural background, significant persons, objects, and activities; and previous hospitalization experiences.

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