Nowadays you don’t even see your neighbours’: loneliness in the everyday lives of older Australians

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Abstract
Loneliness is a pressing social issue for older people globally. Despite this, there is a paucity of studies on how older people themselves perceive loneliness and how service providers can support them. This study sought to address the gap using in-depth and semi-structured interviews with 60 older people and eight focus groups with aged care service providers in Australia in 2007. A purposive sampling strategy was employed to incorporate maximum participant variation. People 65 years and over were recruited from four large service providers in two Australian states. Our findings show that loneliness is influenced by private, relational and temporal dimensions and whether older people feel that they have, or are seen by others as having, a sense of connectedness with the wider community. Participants expressed the importance of maintaining social contact and having a sense of connection and belonging to the community. Our study highlights both the significance of gathering the views of older people to generate an understanding about loneliness and the need to recognise loneliness as a diverse and complex experience, bound to the context in which it is understood and perceived and not synonymous with social isolation. Such an understanding can be used to both evaluate and improve upon programmes that address loneliness and to help maintain an integration of older people in the community.

Keywords: aged care services, loneliness, older people, qualitative research, service and support providers

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Introduction
Loneliness is a pressing global issue, impacting on social well-being and health (Victor et al. 2002, Dykstra et al. 2005, Ekwall et al. 2005, Murphy 2006). Studies have reported that older people are at higher risk of experiencing loneliness due to death of spouses and close friends and onset of disability and illness, which prevent or limit social activities (e.g. Dykstra et al. 2005). This problem is likely to increase as the number of people 65 years and over continues to grow in many developed countries. Previous research has highlighted relationships between loneliness and a number of physical and emotional health problems, including alcoholism, chronic health problems, anxiety, depression, suicidal ideation and suicide (Rokach 1989, Killeen 1998, Ellaway et al. 1999, Hagerty & Williams 1999, Cohen 2000, Tiikkainen & Heikkinen 2005, Barg et al. 2006, Murphy 2006). In addition, loneliness is associated with increased use of health-care services, including an increased risk of premature

In spite of evidence of loneliness being linked to serious health consequences, an examination of the research literature highlights that loneliness is not consistently defined. In part, this is related to ‘a presumption within existing research that there is a common understanding of what it is to be lonely’ (Murphy 2006, p. 22). In addition, loneliness is used interchangeably with the term social isolation (Gardner et al. 1999). Social isolation is also a term that is not consistently defined in literature. Social isolation is considered to be the objective absence or reduction in an older person’s social network, which is distinct from the subjective unpleasant experience of feeling alone or loneliness (Victor et al. 2003). Evidence exists that not all people who are socially isolated are lonely (van Baarsen et al. 2001, Dahlberg 2007). Conversely, some people who have many social contacts and/or are not living alone may still experience loneliness (Holmen et al. 1992, Routasalo & Pitkälä 2003).

The absence of older people’s perspectives in studies about loneliness may contribute to the problems associated with understanding what loneliness is and how it might best be managed. Although studies indicate that loneliness is indeed a tangible part of some older people’s lives, little is offered in relation to how older people themselves understand and perceive loneliness. As Murphy (2006) points out, ‘[t]he majority of studies tend to be quantitative in nature and there is limited exploration of older people’s understanding of loneliness and what they are trying to express when they describe themselves in these ways’ ([emphasis added]) (p. 22). Given that definitions of loneliness often highlight it as a subjective phenomenon, underlining the importance of understanding the experiences of feeling lonely, it is somewhat surprising to note the lack of attention given to older people’s perceptions of loneliness (de Jong Gierveld 1998, Perlmutter 2003).

Equally as important is a consideration of perceptions and views of loneliness held by support and service providers working in the aged care industry. As a cohort of professionals who are in contact with older people frequently, the views of service providers in relation to loneliness are significant as they inform and shape the design of interventions aimed at assisting older people managing loneliness. Yet service providers’ perceptions of loneliness have received very limited research attention. Indeed, a review of the literature revealed only one qualitative study of service providers’ views, which were about social isolation rather than loneliness (Russell & Schofield 1999). While the service providers noted the objective state of minimal social contact, it was the subjective appraisal of the level and quality of social contact that determined whether service providers believed that an older person was socially isolated. In particular, service providers emphasised the lack of meaningful relationships as the main reason why older people were socially isolated rather than the actual number of social contacts or amount of contact. The study, however, does not explain how service providers understand loneliness per se or whether they are able to identify older people who were lonely but not socially isolated.

Therefore, the aim of the study reported here was to understand the perceptions of loneliness held by both older people and those who provide services and support to them. A focus on the understandings of older people and service providers is critical because these perceptions have the potential to inform, support and shape strategies designed to support the everyday needs and lives of older people.

Methodology

A descriptive and exploratory approach sought to facilitate the exploration and interpretation of participants’ perceptions of loneliness. In-depth, semi-structured interviews with older people and focus groups with support and service providers were conducted in two Australian states, South Australia (SA) and Queensland (QLD). The Human Research Ethics Committees of the University of South Australia and Griffith University approved the research.

Participants and settings

Maximum variation purposive sampling was employed to select information-rich participants, described as ‘those from which one can learn a great deal about issues of central importance to the purpose of inquiry’ (Patton 2002, p. 230). Guided by purposive sampling, South Australia and Queensland were chosen as information-rich sites for the study because of their rapid growth in the proportion of people aged 65 and over (Australian Bureau of Statistics (ABS) 2005). The four partner aged care organisations are large providers of care and services to older people, including retirement living, long-term and community care in their respective States and were selected using the strategy of typical site purposive sampling, in that they are ‘not in any major way atypical, extreme, deviant or intensely unusual’ (Patton 2002, p. 236). These organisations compare in size, structure and remit to most other major providers of aged care services in Australia.

Recruitment of older people occurred in 2007 through newsletters and flyers distributed throughout the partner aged care organisations, and using key contact people in each organisation to inform older people
about the study and the opportunity to participate. Furthermore, in keeping with the principles of maximum variation sampling, older people 65 years and over, of varying ages, living in a variety of geographical areas and in varying types of accommodation including long-term care, independent living units, the community; receiving various levels of services and support; and having or not having family or significant others were recruited. Participants did not have to self-identify as lonely, but rather identified themselves as having something to say about loneliness as we were interested in older people’s perspectives of loneliness not just those that identified as lonely. Sixty older people (30 in each State) were interviewed. Participants included 40 women and 20 men with an age ranging from 67 to 92 years.

Recruitment of support and service providers was through the partner aged care organisations and other key stakeholders. Lists of possible participants were drawn together, ensuring that a diverse range of service providers and support workers were invited to participate. Participants in focus group interviews included: nurses and personal care workers who worked in the partner aged care organisations and other health professionals (e.g. allied health professionals such as occupational therapists) who were associated with the study sites in the provision of support and services. Eight focus groups were facilitated, averaging eight participants per group. Focus group participants drew on their experiences of working with older people as well as their personal experiences of loneliness and that of their older family members.

Data collection: interviews and focus groups

Demographic data were collected from each older person interviewed by members of the research team experienced in conducting interviews. The interview then commenced to build a comprehensive description of what each older person understood and perceived loneliness to be. A semi-structured interview guide comprising six probes was used as a basis for exploring participants’ perceptions of loneliness (See Table 1).

All interviews were digitally recorded and transcribed verbatim. The interviews were held at locations convenient for the participants and ranged in length from 20 minutes to 1 hour.

Prior to commencing the focus groups, time was allowed for brief introductions of the focus group facilitator, other researchers in attendance and participants. In addition, the focus group facilitator provided the participants with an overview of the study and explained the roles of participants and observing researchers. The discussion was guided by the same questions used in interviewing the older people. All focus groups were digitally recorded and transcribed verbatim. The focus groups took place at selected sites of the aged care organisations participating in the study and ranged in length from 1½ hours to 2 hours.

Data analysis

Following a thematic analysis approach, interview and focus group transcripts were read through for a sense of the ‘whole’ by at least two researchers in each State (Patton 2002). The researchers then individually identified the categories and themes that recurred in the data. Themes were then discussed and compared drawing attention to similarities and differences in each data set. Following discussions between the researchers, clusters of themes emerged and discussions continued until consensus was reached. The inductive analysis of the data revealed five dimensions that together contribute to understandings of how participants understood and perceived loneliness. The dimensions are interrelated and at times, the boundaries between them are blurred. Four dimensions emerged from the combined interview and focus group data and the fifth dimension (re-adjustment) arose from the focus group data alone.

Findings

The dimensions describe loneliness as: private; relational; connectedness; temporal and re-adjustment. Conveying positive and negative elements of loneliness, the dimensions reveal that how loneliness is understood and perceived is not only diverse and complex, but also bound to the context in which it is experienced. Each dimension is discussed as follows. Data extracts reported in the findings section are selected on the basis of being representative illustrations of the dimensions presented.

Loneliness as private

The participants indicated that loneliness is not only difficult to describe and put into words but also difficult to
speak of and about. Loneliness is perceived as private, personal and a negative experience that often was stigmatised. To tell someone that one is lonely is often associated with shame and shamefulness, as well as failure and defeat. As one older person stated, ‘Society sees it as a nasty problem that they don’t want to know about and also people who are lonely … [feel unable] to express this without feeling that they are a failure of some kind’ (67 year old, female). Viewing loneliness as something one should endure is related to this perception of admission of loneliness as failure and reinforces loneliness as an experience difficult to speak about.

...lots of them went through a war and depression. They came out of that really made to grin and bear everything. So they don’t reach out, they think what they are experiencing ... is how it is ... and you grin and bear it. They don’t jump up and down and say someone help me they kind of wear it (rural support/service provider).

As a private experience, loneliness is understood as personal, subjective and individual. What it means to be lonely for one person may not always be the same for another. Older people in particular offered varying views on why older people experience loneliness. For some, loneliness seemed to be interlinked with the individual’s persona.

The person’s persona for starters, that’s the big one ... if they haven’t got the social skills, if they’ve lost them, maybe through dementia or something like that; that makes it more and more difficult not to have them be lonely (74 year old, male).

For others, loneliness appeared to be influenced by specific experiences such as growing up in large families, living through wars, personal trauma and economic hardships. As one older man stated, ‘Maybe you’ve been kicked in the teeth so many times on the way through life, you are not prepared to open up to anyone’ (74 year old, male). Furthermore, in keeping with the idea of loneliness as a private matter, some participants in the study expressed the view that individuals need to want to help themselves in order to not be lonely.

You have to keep pushing yourself all the time. I am actually conscious of not sitting in my chair. I have to keep getting up and doing something. I am in a fortunate position that I can do that, many people can’t (68 year old, male).

Loneliness as relational

Relationships play an important part in how loneliness is perceived and understood; whether one is lonely or not is shaped by the perceptions of the individual’s relationships with others. When present, the quality of relationships was perceived as especially important. Just having relationships was not enough. Indeed poor relationships could result in feelings and perceptions of loneliness.

...they have passed the stage of being involved with their family and they are no longer actually needed ... they do feel this way because they had a family and they have helped all along and now they just feel a bit down... (83 year old, female).

Conversely the presence of quality relationships assisted in preventing loneliness.

If you have companionship then you are not lonely, because you have someone with you. Even if you don’t see each other much during the day, at least you are crossing paths during the day. Your husband is doing jobs outside, you know he is there, you can feel him, and you are not lonely because you have him there. But when he is not there, I am just so lonely (82 year old, female).

In discussing companionship, participants indicated that there were different ways through which it could be gained. This included relationships with spouses, family members, friends, neighbours and pets. Furthermore, companionship could include contact with professional care workers, although care workers outlined that such intentions were not unproblematic. The amount of time allocated to seeing each client was seen as a challenge in that it did not allow additional time for interaction with an older person who was potentially quite lonely.

It is very hard as well to be a care worker sometimes and to think to yourself; oh gosh if I go in there she is going to want me to stay. I haven’t got 10 minutes to spare and that is really hard and makes you feel really guilty that you haven’t got 10 minutes to spend with them (rural, support/service provider).

In addition, the importance of physical human contact and a lack of human touch was recognised as something, which could contribute to perceptions of loneliness. As one service support/service provider explained:

They are all little deprivations as you enter from one stage into the next of your life, the end of your life, loneliness or even those of us happy within our own selves, we can cope with that. Some can’t. They miss that arm around, touching of the hand, the kiss on the cheek (rural, support/service provider).

However, even providing the occasional hug and/or touching an arm or hand were considered to be challenging. One care worker stated: ‘If you do act like that towards the elderly, you are looked upon as being weird, a bit strange, if you give someone a hug, you shouldn’t get too close, it is not professional...’ (rural support/service provider).
Loneliness as connectedness

Having a sense of connection to the community at large was significant in respect to how the participants understood loneliness. This dimension highlighted the importance of older people having, and maintaining, a sense of belonging to others, whether it be in their immediate communities, or in the society at large.

Times have changed. Once upon a time the postman came, the bread man delivered the bread, and the milkman delivered the milk. You knew all these people ... nowadays you don’t even see your neighbours, you don’t know them hardly (89 year old, female).

Feeling disconnected also related to feeling not needed or not part of society.

It’s nice to be needed or wanted to be asked advice ... but a lot of the old folks are just so reluctant to offer other things and they feel ‘we’re no longer needed’. That’s a terribly depressing thought – I am just no longer needed. They say if I am no longer here, nobody would miss me (83 year old, female).

Sometimes I think ... you are not included in the sort of general population. You pick up the Women’s Weekly, [women’s magazine] at one stage it used to be a fairly general magazine, now there is nothing for the elderly, no hints or tips on nutrition for the elderly or fashion designs. You would think we are an endangered species. We don’t really matter (85 year old, female).

In further contrast with feeling connected or disconnected was a feeling of being unconnected. Being unconnected resulted in feeling like a stranger in a place, of being unable to connect with individual people and the community at large because the connections were not already there, or not possible to make. The experience of feeling isolated from everyone and everything is one such example.

Support and service providers indicated that being able to respond to older people’s loneliness may require doing things that will enable older people to maintain old connections (addressing what we have termed disconnection), and develop new ones when the previous ones disappear (addressing possibilities of being unconnected), be it with their peers, family or community. However, a cautionary note was expressed by focus group participants that providing services could not be done in a ‘one size fits all approach’.

I think it is also taking the time to know that person. You can’t really come in with a McDonald’s menu for people, you have to take the time to get to know the person and ... explore all the options that may be available or options that would suit them (metropolitan support/service provider).

Loneliness as temporal

The views and perceptions of older people in particular suggested that loneliness has something to do with time. This can be related specifically to the time of day, time of the year or more broadly to the time of life. For instance, some older people indicated that they experience loneliness most keenly at night even if the daytime is full and satisfying. As one participant stated, ‘You can still get lonely when you get into bed at night, during the day you are too busy trying to occupy your mind’ (73 year old, female).

This has been further exemplified by the change in the seasons,

As I said I can honestly say that [loneliness] I have experienced that in one or another, especially through the winter in particular, it can be a very lonely and depressing time. We don’t see a sign of a soul. Others have said the same thing to me. In the winter when it is overcast and grey, it may not be raining but it is cold, you shut yourself in your unit and it is the same in a house and you don’t see a soul and it can be very depressing and lonely (80 year old, female).

In this sense, loneliness is an experience that can come and go and is not necessarily a defining or permanent feature associated with older people.

When identified as something that shifts between different points and stages of life, loneliness was often understood in relation to a time of loss, and in particular, the process of grieving someone’s death.

Loneliness to me is losing your loved ones, like I lost my mum and I lost my husband ... A part of you goes with them and I think, I mean you can rebuild your life, you bubble up ... but to me that is loneliness’ (75 year old, female).

Participants were aware of the need to manage the times in their life where they experienced loneliness and they spoke about being active agents in managing loneliness. Strategies used to manage loneliness included adopting a positive attitude and keeping busy engaging in activities, which were meaningful.

Loneliness as re-adjustment

The support/service providers perceived loneliness in older people as being influenced by whether the older person was able to adjust to losses and changes in everyday life such as occurs with the death of someone who played an important role in older people’s lives for a long time, such as a spouse. This also leads some older people to re-evaluate their lives, since the possibility of dying is more real than ever. ‘They question their faith. What is it all about? Probably their own mortality as
well. It is all related to dying’. (metropolitan support/service provider)

Service providers highlighted that the need to adjust to losses and changes in everyday life often corresponded to losses associated with deterioration in health status. Reduced mobility for example could impact on loneliness.

The hospital system, waiting for hip replacements, or knee replacements, I think this causes a lot of loneliness because people’s ability to actually drive their car or go out is diminished because of pain, they can’t sit for a long time, so they tend to say no I am useless, I am embarrassed because I have to stand up every now and again, so they will isolate themselves (metropolitan support/service provider).

The adjustment that is required with a move to a retirement village or long-term care as a result of an older person becoming increasingly dependent on others was also considered as a potential factor in relation to a feeling of loneliness.

...someone moves from their community into a facility ... loss of your normal surrounding, normal environment, that would all impact on suddenly being in a place with people you don’t know and staff you don’t know ... we like to think that everyone has choices about where they live, practically that is not able to be supported simply because of the amount of care and services they may need...(rural support/service provider).

In this way, losses and changes may lead to a loss of purpose and belonging – something that may be initially difficult to deal with for some older people.

One way that service providers enabled older people to manage the readjustment to losses was by engaging them in activities that were meaningful.

We have two men at the moment and they have always been fishermen, so now we take them fishing once a month. Once a month we take them down to the wharf and we have the rods and we get the bait and go fishing...It gives them a sense of achievement even though most times they don’t catch anything, it is not the fact they have caught nothing, it is the fact of just going out and actually doing what they used to be able to do. They come home very happy (rural support/service provider).

Another approach to assist with readjustment and management of loneliness was to participate in activities through which older people saw themselves as contributing to the lives of others.

There is a gentlemen who has ... just retired and he says it’s my turn to give back to the community, he has a smile on his face all day, just helping pick up people, bring them to the centre, a bit of maintenance around their organisation... (rural support/service provider).

Discussion

The review of literature indicated that loneliness is a term used widely in discussing older people, yet despite this it is one that is not consistently defined or well understood. Drawing on perceptions and understandings articulated by older people and those who provide services and support to them, the findings of this study highlight the inter-related dimensions that emerged from participants’ understandings of what loneliness is. At any point in time, loneliness is understood by reference to one or more of the dimensions. This is particularly evident around times of loss or transition, resulting in feelings of disconnection and/or unconnection. Loneliness is constantly changing in terms of nuances and emphasis, depending on the individual person and what they are experiencing in their life. The findings support definitions of loneliness as a subjective phenomenon, further underlining the importance of understanding the experiences of feeling lonely (de Jong Gierveld 1998, Perlman 2003). By better understanding individuals’ experiences of loneliness and its complexity, more effective and sustainable strategies can be created to enable and assist older people to address loneliness (Cattan et al. 2005).

The participants in the study did not understand loneliness as synonymous with social isolation. Our findings support Killeen’s (1998, p. 764) assertion that:

Someone alone is obviously by themselves, and therefore they might be lonely, but this might not be the case at all. Loneliness describes somebody who feels that they are by themselves, that they have no choice in the matter, and that they do not want to be in that condition. The term solitude may better reflect an element of choice in wanting to be by oneself, which might be preferred to being with other people.

As Killeen sums up: ‘you can be lonely in a crowd’ (1998, p. 764). Participants in the study reported here also talked about feeling unconnected in new settings where there were many people around, such as in organised group activities. This is in keeping with other studies reporting that people living in institutional settings, for instance, sometimes feel lonely despite being surrounded by others (Tijhuis et al. 1999). Thus, while our study supports that social isolation is indeed part of older people’s experiences of loneliness, as demonstrated by Gardner et al. (1999), it also reveals that social isolation does not encompass the array of experiences that constitute loneliness. That is, while loneliness and social isolation are related, the former cannot entirely explain the latter, because like Ekwall et al. (2005), we found that loneliness as a phenomenon is complex and multidimensional” (p. 24). We are not suggesting that programmes, which aim
to reduce social isolation, are not necessary, but rather caution against making assumptions that loneliness and social isolation are synonymous, as it risks overlooking and/or under-supporting those who experience loneliness yet are not socially isolated.

The multidimensional nature of loneliness with its five dimensions has implications for the ways that loneliness is thought about and managed. Strategies to address loneliness are called for that take into account the complex and multilayered nature of loneliness. Mapping of both existing and potential programmes against the dimensions will enable identification of not only the strengths but also the gaps in services for older people. Indeed, we would argue that ongoing and new funding for services related to loneliness are provided only for strategies that take the multilayered complexity of loneliness into account.

Despite having to face challenges associated with experiencing loneliness and ageing, older people continue to be active in negotiating and adapting to the shifts and changes that come with loneliness. This demonstrated that older people have a sense of agency. Service provision needs to maximise the ability of older people to exert agency and be provided in ways that are empowering and enabling, and avoid the creation of dependency.

Keeping positive and busy were strategies that older people used as active agents in managing their own loneliness. A potential avenue for further interventional research is an exploration of the efficacy of participation in meaningful activities compared to social contact for reducing loneliness. Keeping busy and engaged in meaningful activities, such as helping others, enables older people to play an active part in their own lives, increasing the likelihood of gaining a sense of being needed and wanted and feeling like they can still contribute despite decreased functional abilities.

The dimensions of connectedness, temporality and re-adjustment give an indication of particular times when older people are most vulnerable to loneliness. This gives service providers direction not only for when to provide supports, but also when to put prevention strategies in place to be the most effective. Relocation or loss of a significant relationship are obvious times within an older person’s life that require adaptation and adjustment and have the potential to result in feelings of disconnection and loneliness, as well as consideration of particular times of the year, day or week when older people require more support. Given the stigma of loneliness and the difficulty of identifying older people who are lonely, it appears that a focus is required on primary health care and prevention strategies.

This is one of the few studies of loneliness that includes service providers’ perspectives. Interestingly, four of the dimensions were common to the older people and the service providers, with the dimension of adjustment only coming from the service provider data. While at one level it is reassuring that service providers hold similar understandings to older people, it is perhaps not surprising that they might also provide a broader view than that held by individuals. Further work is recommended with service providers in other parts of Australia and internationally.

Despite service providers holding similar understandings of loneliness to older people, there remains the issue of stigma and privacy and difficulties in identifying people who are lonely. The reluctance of individuals to reveal that they are lonely makes identification of individuals who could benefit from assistance difficult and needs much further exploration. It is our contention that loneliness needs to be addressed at not only the individual level, but also the community level in combating stigma. While the societal stigma of loneliness remains, it will be difficult for older people to manage effectively their own loneliness and limit the effectiveness of intervention programmes. Programmes that more broadly target well-being for older people may be more successful.

While older people in both metropolitan and rural areas of two states of Australia participated in the study, a potential limitation is the lack of data for older people from remote areas of Australia. The issues for older people living in more remote areas of the country warrant exploration. Furthermore, family members were not included in the focus groups, apart from service delivery workers who had older family members who may have experienced loneliness and could speak about their personal experience. However, as the focus of the enquiry was on their perspective as a service provider, it is recommended that further study is conducted to gain a better understanding of the perspective of family members.

**Conclusion**

In conclusion, the study has gained the perspectives of both older people and service providers’ understandings of what loneliness is. The resultant findings indicated five different but interrelated dimensions of loneliness, being private, relational, re-adjustment, temporal and connectedness. The description of the dimensions of loneliness can be used to inform service provision both to refine existing programmes and to design new programmes that might address current gaps in service provision. Programmes that include primary healthcare approaches and strategies that empower older people together with strategies to combat stigma at a societal level will lead to better health and well-being.
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Conflict of interest

No conflicts of interest have been declared.

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