INSTITUTE FOR
QUALITY OF LIFE

sodexo

Social interaction, loneliness
and Quality of Life in healthcare
and older adults' care

As an in-house 'think-tank', the Sodexo Institute for Quality of Life is inspired by Sodexo's deeply held conviction that improving Quality of Life leads to the progress of individuals and contributes to the performance of organisations. Its role is to gather and develop insight to help Sodexo understand better what are the levers of Quality of Life.

This report is inspired by the Sodexo Institute for Quality of Life Dialogue that took place in Ottawa, Canada, on 23 September 2014 and whose participants were:

Bishop's University
Dr. Fuschia Sirois, Professor of Psychology

CCAL - Advancing Person-Centered Living
Karen Love, Founder

Front Porch
Dr. Lauren Moulton-Beaudry, Director of Ethics and Education

Leading Age
Dr. Cheryl Phillips, Senior Vice President for Advocacy and Public Policy

Les Petit Frères
Caroline Sauriol, Managing Director

Planetree
Lucie Dumas, President and CEO (Quebec)
Dr. Susan Frampton, President (US)

Université de Sherbrooke
Dr. Mélanie Levasseur, Professor at the School of Rehabilitation

University of Toronto
Grayson Bass, Founder of the Mayer Wilson D-Institute Initiative at the Rotman School of Business

Virginia Polytechnic Institute and State University (Virginia Tech)
Dr. M. Joseph Sirgy, Professor of Marketing and Virginia Real Estate Research Fellow

Sodexo Group
Laurent Cousin, Senior Vice President for Marketing Offer, Research & Development - On-site Service Solutions
Isabelle Honoré, Deputy Director, Sodexo Institute for Quality of Life
Shelley Kalfas, Vice President for Marketing, Healthcare, US
Thomas Jelley, Director, Sodexo Institute for Quality of Life
Marie-Hélène Sicard, Senior Vice President for Corporate Services, Canada
David Simic, Vice President for Business Development, Comfort Keepers

Quality of life in long-term care includes "intangible" factors such as consumer choice, autonomy, dignity, individuality, comfort, well-being, security and, most importantly in the context of this report, relationships and meaningful social activity

Introduction

Managing social interaction and loneliness in healthcare and older adults' care settings is the focus of much contemporary research and public policy. Social interaction and loneliness impact the quality of life of patients, older adults, families, carers and workers, including their ability to progress and the performance of organisations across the public, private and not-for-profit sectors. However, the literature and discourse on healthcare and older adults' care points increasingly to:

■ a care deficit, both in funding and in human terms, with insufficient carers available to provide the right type and level of care to those who need it;

■ the healthcare sector faces funding challenges across the world at a time when many populations are ageing rapidly and the dependency ratio is falling. This is necessarily a concern across policy, practice and private spheres; and

■ demographic shifts in the first half of the 21st century will not ease care challenges: across the OECD[1], the proportion of the population aged 80 and over is predicted to increase from 4% in 2010 to almost 10% by 2050.

According to the OECD, quality of life in long-term care includes: "intangible" factors such as consumer choice, autonomy, dignity, individuality, comfort, well-being, security and, most importantly in the context of this report, relationships and meaningful social activity. To participate in the solution to the challenges we face in social interaction, loneliness and quality of life in healthcare and older adults' care, we must first raise our awareness and understanding of these challenges.

1 - OECD / European Commission (2013), A Good Life in Old Age? Monitoring and Improving Quality in Longterm Care, OECD Health Policy Studies, OECD Publishing. http://dx.doi.org/10.1787/9789264194564-en

To explore them, we will consider social interaction and loneliness from a quality of life perspective in three parts:

- emotions
- the changing profile of carers
- taking care with technology

The purpose of this report is to increase understanding of loneliness and social interaction to improve the quality of life of patients, older adults and carers, so they can progress and the organisations near them can perform better.

1. Emotions

In a leading academic exposition that stands the test of time, 'loneliness' is defined with a strong subjective emphasis as:

"...a situation experienced by the individual as one where there is an unpleasant or inadmissible lack of (quality of) certain relationships. This includes situations in which a number of existing relationships is smaller than considered desirable or admissible or situations where the intimacy one wishes for has not been realised. Thus, loneliness is seen to involve the manner in which a person experiences and evaluates his or her isolation and lack of communication with other people."[2]

The UCLA Loneliness Scale[3] is among the most popular metrics of loneliness used by scholars in this area (see Annex 1). This scale illustrates the importance attached to subjective appreciation of loneliness through questions designed to ascertain how often the individual the subject of the assessment feels in certain ways in relation to others.

Loneliness is seen to involve the manner in which a person experiences and evaluates his or her isolation and lack of communication with other people

2 - De Jong Gierveld (1987), Developing and testing a model of loneliness; Journal of Personality and Social Psychology, 53, 119-128, p.120
3 - Russell D. W. (1996), UCLA Loneliness Scale (version 3); Reliability, validity, and factor structure; Journal of Personality Assessment, 66, 20-40

Loneliness impacts satisfaction in other major life domains such as satisfaction with family life, work life, community life, spiritual life, love life and leisure life

More recently, loneliness has been construed in terms of three dimensions[4], namely:

- an absence of intimate connectedness (i.e., lack of intimate, romantic relationship, lack of connection with immediate family members);
- an absence of relational connectedness (i.e., lack of authentic friendships, lack of people that one can confide to; lack of social support); and
- an absence of collective connectedness (i.e., lack of belongingness to referent groups that one can identify with and call one's own).
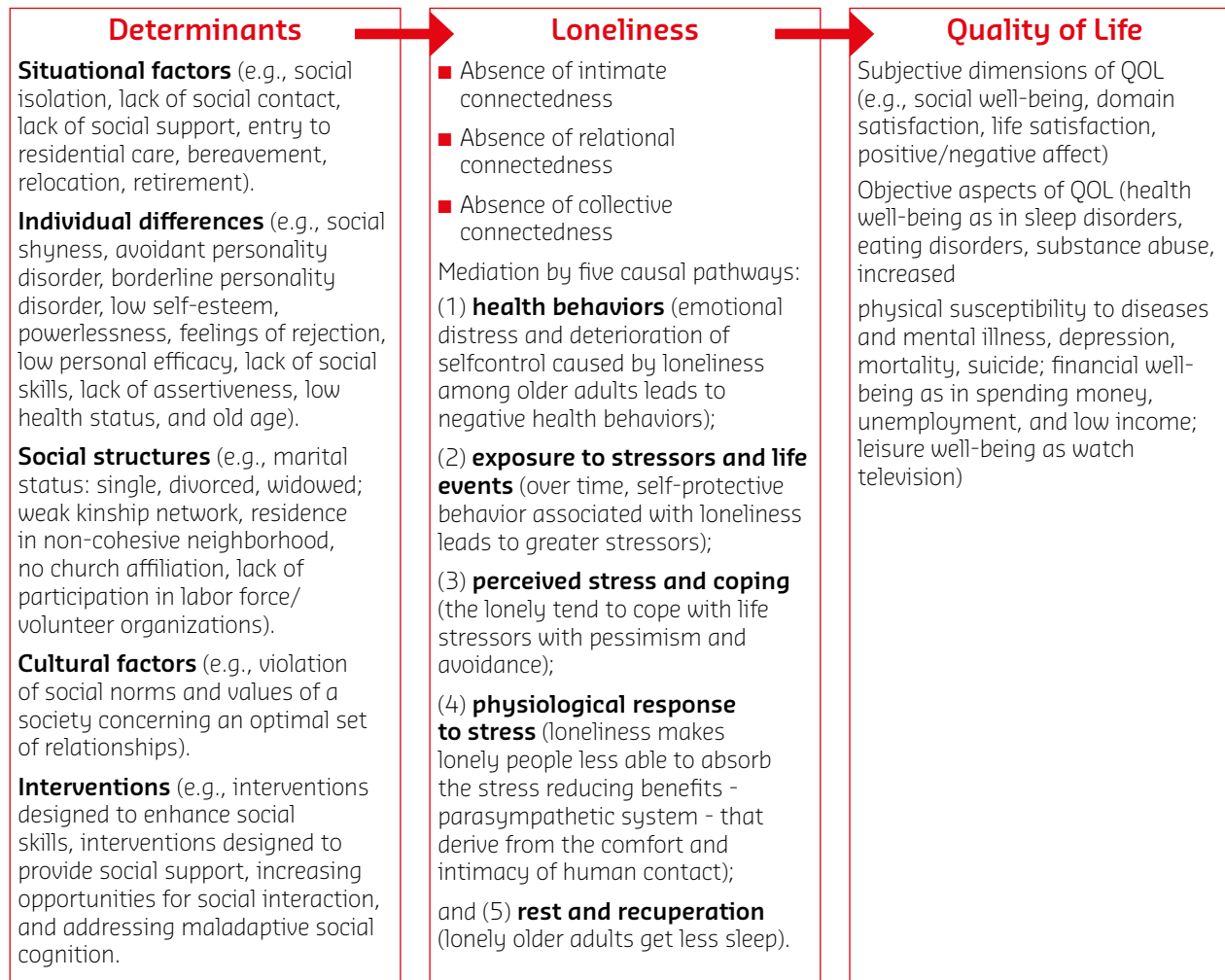
Loneliness has both subjective and objective impacts on quality of life. Much research has documented the effects of loneliness on subjective well-being, specifically overall satisfaction with social life (the sense of social well-being), overall life satisfaction, and emotional well-being (positive and negative affect). Additionally, much evidence points to the fact that loneliness impacts satisfaction in other major life domains such as satisfaction with family life, work life, community life, spiritual life, love life and leisure life. Objective considerations in the evaluation of loneliness include its impact on:

- **health-related wellbeing** in relation to sleeping and eating disorders, substance abuse, increased susceptibility to disease, mental illness, depression and suicide;
- **financial wellbeing** through unnecessary spending, unemployment and lower income; and
- **leisure wellbeing** through excessive television watching or online gaming.

If we keep in mind the three levels of loneliness above based on proximity to the individual - a lack of intimate connectedness, the absence of relational connectedness and the absence of collective connectedness - the following framework[5] helps to explain the determinants of loneliness and its impact on quality of life.

4 - Cacioppo J. T. and Patrick W. (2008); Loneliness: Human nature and the need for social connection; WW Norton & Company.
5 - Sirgy, M. Joseph (2014). Loneliness as experienced by the elderly: Construct, antecedents and consequences. Presentation at the Sodexo Institute for Quality of Life Dialogue 'Social interaction, loneliness and Quality of Life in healthcare and older adults' care', Ottawa, Canada, September 2014.

Determinants

Situational factors (e.g., social isolation, lack of social contact, lack of social support, entry to residential care, bereavement, relocation, retirement).

Individual differences (e.g., social shyness, avoidant personality disorder, borderline personality disorder, low self-esteem, powerlessness, feelings of rejection, low personal efficacy, lack of social skills, lack of assertiveness, low health status, and old age).

Social structures (e.g., marital status: single, divorced, widowed; weak kinship network, residence in non-cohesive neighborhood, no church affiliation, lack of participation in labor force/ volunteer organizations).

Cultural factors (e.g., violation of social norms and values of a society concerning an optimal set of relationships).

Interventions (e.g., interventions designed to enhance social skills, interventions designed to provide social support, increasing opportunities for social interaction, and addressing maladaptive social cognition.

Loneliness

- Absence of intimate connectedness
- Absence of relational connectedness
- Absence of collective connectedness

Mediation by five causal pathways:

(1) **health behaviors** (emotional distress and deterioration of selfcontrol caused by loneliness among older adults leads to negative health behaviors);

(2) **exposure to stressors and life events** (over time, self-protective behavior associated with loneliness leads to greater stressors);

(3) **perceived stress and coping** (the lonely tend to cope with life stressors with pessimism and avoidance);

(4) **physiological response to stress** (loneliness makes lonely people less able to absorb the stress reducing benefits - parasympathetic system - that derive from the comfort and intimacy of human contact);

and (5) **rest and recuperation** (lonely older adults get less sleep).

Quality of Life

Subjective dimensions of QOL (e.g., social well-being, domain satisfaction, life satisfaction, positive/negative affect)

Objective aspects of QOL (health well-being as in sleep disorders, eating disorders, substance abuse, increased

physical susceptibility to diseases and mental illness, depression, mortality, suicide; financial well-being as in spending money, unemployment, and low income; leisure well-being as watch television)

At an individual level, the loss of autonomy over aspects of daily routine such as food and visiting hours which are often daily highlights for the human interaction they bring, should not be overlooked

The determinants of loneliness shown in the framework on page 6 present a range of factors to consider. These vary from situational factors that may be recent or short term - which an individual can adapt to or which can themselves be adapted, to deeply embedded cultural or personality-based determinants that are more difficult to change. Nonetheless, the range of factors indicates that there are numerous perspectives from which to consider the causes of loneliness, and therefore many potential entry points to mitigate it.

With this in mind, the remainder of this section will consider:

■ emotions that are connected to loneliness;

■ emotions that can mitigate feelings of loneliness; and

■ emotions at the heart of caring.

These emotional states are acknowledged in the field of health psychology, a specialisation for positive adjustment to health events that includes work on selfcompassion, the avoidance of self-criticism and the science of gratitude.

(a) By way of illustration, the range of emotions[6] connected to loneliness that can be experienced in parallel by patients, older adults and indeed their carers, includes:

- **aggression**, connected to loneliness as it can be manifested when individuals become over-protective of themselves over time.

- **autonomy**, described as the ability to do things because you want to, rather than because others tell you to. It is a sense that can be lost through physical or mental impairment. As autonomy diminishes, feelings of belonging and being part of society (which come more easily in smaller environments that are less institutional) become more important to individuals' self-image. At an individual level, the loss of autonomy over aspects of daily routine such as food and visiting hours which are often daily highlights for the human interaction they bring, should not be overlooked.

6 - As discussed by experts during the Sodexo Institute for Quality of Life Dialogue that inspired this report (Ottawa, Canada, 23 September 2014).

While we all experience physical change to varying degrees as a result of health events and ageing, what makes us who we are remains relatively unchanged save with the onset of cognitive problems. However, in care settings there is a danger that we seek to protect people to such an extent that their autonomy is unnecessarily diminished. This can lead to a 'safety surplus' resulting in little or no participation in activities that individuals are passionate about. These activities can be 'daily' but also personally meaningful, such as cooking, gardening or mobility. A knock-on effect of reduced, safety surplus-induced autonomy is loss of dignity.

- **fear** is commonplace for individuals in care settings, often unfamiliar environments, where the experience can be acute or chronic leading to anxiety which magnifies loneliness. Some deal with this fear alone while others mingle and talk about it to anyone who will listen - especially actively - whether clinical staff / professional carer or not.

- **stress** related to loneliness is not experienced in the same way by all individuals: we have different adaptation levels of loneliness at which we feel comfortable. The perception of stressors is accentuated by the lonely and contributes to pessimism. In most people, the parasympathetic system operates after the experience of stress to help recovery. This is not the case of lonely people whose parasympathetic system is weak and has little calming effect owing to the absence of contact or intimacy with other people. One of the consequences is less or reduced quality of sleep which can lead to fatigue over time. One of the factors in individuals' adaptation level of loneliness is culture; this is reflected in some popular stereotyping, for example 'vivacious', collectivistic Latin and African cultures contrasted with 'subdued', individualistic, Anglo-Saxon or Nordic cultures.

(b) Having described some of the connections between loneliness and other emotions, we note how the most positive among them - gratitude and hope - can be used actively by patients, older adults or those involved in their care to mitigate loneliness. For example:

- **gratitude** (e.g. for social relationships) is connected to loneliness in that it helps individuals to realise the value of the social connections they have. Gratitude helps with sleep quantity and quality if practised at the end of the day. If patients and older adults focus on the

Fear is commonplace for individuals in care settings, often unfamiliar environments, where the experience can be acute or chronic leading to anxiety which magnifies loneliness

Compassion and empathy
represent a chasm between
human beings and artificial
intelligence and are the most
likely emotions to shape our
approach to social interaction
and loneliness as we tackle
the care deficit

intersection of daily activities and social interaction while drawing on life experiences, they live more opportunities to appreciate and be grateful for their accomplishments even as they face current challenges.

While individuals have different predispositions to gratitude, even the socially functionally limited can feel it. There is a degree of skill in gratitude and it can be taught to an extent though overly habitual gratitude can diminish its impact.

- **hope** (which can be related to faith) is a powerful construct that can help individuals through the experience of a health event or later year' challenges. It can be nurtured in ways that range from pastoral care based on religious belief to short term habit-breaking support. For example, social support organisations that tackle substance abuse or conditions such as obesity – both of which can be lonely – involve guided opportunities for social interaction. There are also methods (such as cognitive behavioural therapy) to address maladaptive social cognition through practices to reverse negative feedback loops of negative beliefs which reinforce negative behaviours which in turn exacerbate the original belief.

(c) The emotions at the heart of caring are compassion and empathy. They represent a chasm between human beings and artificial intelligence and are the most likely emotions to shape our approach to social interaction and loneliness as we tackle the care deficit:

- **compassion** is the feeling that drives the motivation to help others in need, including the lonely as they experience an "inadmissible lack of (quality of) certain relationships". In healthcare contexts, compassion has evolved from being perceived as 'soft' and on the side-lines of care, to being at its core. There is a growing focus on how to define, measure and track compassion. Indeed, in research on the impact of authentic human relationships between patients and carers, bedside manner has been found to have a greater impact than cholesterol-lowering drugs on high cardiac risk patients;
- **empathy** is closely related to compassion and plays an important role far beyond the immediacy of interpersonal exchange. It is also a cornerstone of community wealth, a tool for community empowerment that is in evidence when carers are seen to ask the right questions of those in need. It includes the practice of asking those who are cared for about social interaction hopes and needs beyond the provision of daily activities (such as dressing, eating, bathing etc.) and linking them to local possibilities.

The emotions related to loneliness, social interaction and quality of life in healthcare and older adults' care settings are certainly complex. For example, they blend 'autonomy' which may be related to physical and cognitive ability, with 'hope' which ranges from that which can be nurtured to the most deeply felt questions of religious faith. A further complication is that while some emotions are more readily associated with those receiving care, care givers are also susceptible to loneliness and connected emotions. Fortunately, the development or practice of gratitude and hope can help individuals who feel the compassion and empathy of others is insufficient to meet their needs. This may prove invaluable to many as the profile of carers continues to change from historically family-based provision to services provided by people and organisations based outside the home.

2. The changing profile of carers

In evolutionary terms, we are now younger longer (with fewer care needs) and older longer (with more care needs) than ever before, and the profile of carers is changing owing to a number of trends including the following:

- women, who have historically done so much unpaid family-based caring, are an increasingly large proportion of the out-of-home working population;

- living arrangements also have an impact on caring, and multi-generation households beyond parents and children - a basis for flexible care arrangements - are rare in more numerous industrialised countries;

- single-person households are increasingly common in industrialised countries; and

- even where informal care is provided, carers such as family members are often comfortable meeting their charge's daily needs but struggle with aspects of social interaction that often require the support of local organisations for practicalities such as mobility and convening others.

The net result of these changes and challenges is relatively fewer people available to care for growing needs and greater pressures on carers, whether professional or not, and the burden of caring will continue to change in light of well-established predictions of demographic shifts towards an older adults-heavy dependency ratio.

In evolutionary terms, we are now younger longer (with fewer care needs) and older longer (with more care needs) than ever before, and the profile of carers is changing

One of the reasons that non-clinical services workers can have an impact on loneliness, support a sense of connectedness and even help to relieve fear or anxiety is that, in some instances, they are seen as being 'safe' and nonthreatening

In these circumstances, the role of clinicians and other professional carers is already the subject of much attention and development. This is necessary and welcome but many other workers are involved in care settings and should also be considered: porters, cleaners, foodservice assistants, receptionists and drivers to name but a few. Though these services workers are neither clinically trained nor family members, they are very much a part of care settings and their contribution to managing loneliness and social interaction also matters; the remainder of this section considers their role.

Despite exacting standards, teaching services workers in care settings the 'textbook' skills to serve people and maintain care environments may be seen as relatively straight-forward. Training such workers beyond the specific services that they provide is more complex but a valuable differentiator as a critical aspect of their work includes listening, engaging and interacting with patients and older adults. Indeed, one of the reasons that non-clinical services workers can have an impact on loneliness, support a sense of connectedness and even help to relieve fear or anxiety is that, in some instances, they are seen as being 'safe' and nonthreatening.

Service workers need training to help them feel comfortable in care settings and the first step towards this is to address their own experience. An example might be the smile and helpful words of the hospital porter whose insight is based on her training experience of being dressed in a hospital gown, wheeled through the corridors from the ward to the lift, then into an operating theatre of waiting clinicians.

Individuals like this imagined porter also work and behave differently when they feel trusted and have 'permission' to exercise judgment, for example in relation to the safety surplus referred to above or the closely related 'dignity of risk'. A systemic approach to best practice is needed within organisations starting with senior leadership behaviours, role-modelling, and a review of the distance between often the laudable, lofty, mission statements and values of an organisation, and the daily practices that make up its performance.

There is another, very different, side to the experience of carers and services workers: their own feelings of loneliness and social interaction needs. Such individuals can benefit from opportunities to connect with peers to know that their experiences and feelings are not unusual and can, at least in part, be mitigated by the practice of gratitude as noted above. Nonetheless, it is often difficult

to stop and take stock so practices such as annual 'memorial days' or networks where individuals can talk about their care-related burdens may also provide welcome release and help them to avoid loneliness.

Finally, just as to forget the individual identity of the patient or person cared for is to deny the existence of the person, cross-cultural and language differences that often exist in healthcare and older adult care environments must be addressed, from the perspective of the individual, the family, carers and other workers. One way of putting this into practice is to include stakeholders in service co-design and the recruitment of carers and services workers who will share responsibility for individuals' quality of life in challenging circumstances whether at home, in a hospital or a residential facility.

3. Taking care with technology

So far, we have explored emotions related to loneliness, and the changing profile of carers with a clear emphasis on people. While it is argued that *"It is surely* [human]... *understanding that makes for genuine care"*[7] or the empathy and compassion referred to above, technology is a long-standing feature of the discourse.

One example of this is robotics. When a processing-chip maker's healthcare robot was first introduced into hospitals to deliver meals and medicines in the 1980s, it is said that people tried to obstruct it by tripping it up. By contrast, thirty years later, it is said that some patients find it easier to speak openly to healthcare avatars than to real people. Would they also pat a modern medicine-dispensing and mealserving robot affectionately on the head like a trusted and loyal companion?

Without seeking to predict how the relationships of patients and older adults with technology will evolve or how carers will use data, they are undeniably drivers of change in the way we manage loneliness and social interaction. To illustrate this, set out below are three very different concerns followed by examples of local communities enriched by social media to show what is possible when care is taken with technology.

Cross-cultural and language differences that often exist in healthcare and older adult care environments must be addressed, from the perspective of the individual, the family, carers and other workers

7 - The Royal Institute of International Affairs, The World Today, October & November 2014, p. 22

We should resist the temptation to ignore new uses of existing infrastructure in the face of blinding advances in communication technology and data

Data and intimacy

In human relationships, the more information we gather about an individual, the more intimate the relationship we are able to have with them. The same may not be true of over-reliance on 'big data' resulting in little intimacy. This is because carers need to remain present in the moment, listen authentically to people, and not simply harvest data from systems to 'know' individuals.

People contact first

Physical connectedness should come first; technology is better suited to playing a role over distance and time once the foundations of meaningful social interaction have been established well. Even then, there is a danger that increasing connectivity will result in more frequent feelings of loneliness and boredom when not connected (e.g. to social media) than was the case before the availability of such connectivity. In a similar vein, technology and social media tempt us to compare ourselves to others rather than truly understand the adequacy of what we already have and value it.

Progress is not just technological

Though access to high-speed internet connectivity continues to grow, barriers to digital inclusion and literacy remain and individuals still need out of home social interaction. Relatively low-tech assets, such as adapted transport to take people to hospitals or day-centres, have a role to play and improvements to existing amenity can still be made e.g. transporting people to a restaurant or to see friends. We should resist the temptation to ignore new uses of existing infrastructure in the face of blinding advances in communication technology and data.

Balanced against such concerns are examples of technology-enabled innovation that is inspiring hope for many. They enhance local communities by combining much of what we have already discussed. The following initiatives feature care, connection and interaction, innovation and technology, they are designed to enhance local communities:

- a secure online social network of people including neighbours, shop-keepers, the postal delivery person, the pharmacist, hairdresser or bus-driver, who informally share the burden of keeping an eye on a vulnerable person: they use the social network to post messages about the vulnerable person's wellbeing

- a smartphone app that allows users to see how close family, friends or carers are
- a secure online social network based around older adults who can offer help to others such as taking delivery of a parcel or letting an electrician into a neighbour's home during working hours
- a smartphone app that alerts bus drivers to the presence of a passenger who needs longer to cross the road, board or step off a bus
- robots that dispense the right medicines in the prescribed dose at the right times and can alert a carer or physician if needed

To seek a definitive position on the impact of technology on social interaction and loneliness in healthcare and older adult care settings is likely to miss the point. As service providers focus increasingly on their end users' experience, the potential impact of technology in service delivery should be considered on a case by case basis, as a decision-making criterion that can hinder or enhance social interaction depending on use.

Summary and conclusion

In our consideration of social interaction, loneliness and quality of life in healthcare and older adults' care, we have explored a range of emotions. We have seen that loneliness is defined in subjective terms with regard to the individual in question but also with reference to objective indicators related to sleep, financial wellbeing or psychological wellbeing among others. A variety of determinants ranging from the individual and short term to the cultural and long term can lead to feelings of loneliness in intimate, relational or collective terms.

From the perspective of the patient or older adult, loneliness may be experienced in parallel with a number of related emotions such as aggression, stress or feelings of loss of autonomy. In carers, the emotions that are most likely to help mitigate loneliness in others are compassion and empathy, though carers also have needs that must be managed both for their own progress and the performance of their organisation.

Owing to unprecedented demographic shifts, the profile of carers is changing significantly and will continue to do so. One of the consequences is increased reliance on professional carers and the growing number of services workers without whom healthcare and older adult care environments could not operate.

As service providers focus increasingly on their end users' experience, the potential impact of technology in service delivery should be considered on a case by case basis, as a decision-making criterion that can hinder or enhance social interaction depending on use

We must take care with technology and avoid the temptation to think and behave as if technology can take care

As these workers can also play an important role in the management of social interaction and loneliness for patients and older adults, their training and needs must be addressed.

Taking care with technology opens up a range of possibilities to enhance care communities with social networks and the unprecedented availability of data. However, these possibilities are balanced by the very essence of the notions of loneliness and social interaction that still have contact between people at their core.

The emotions related to loneliness and social interaction have an impact on many aspects of quality of life, with consequences for the progress of individuals and the performance of organisations in healthcare and older adult care settings. It will remain pertinent for policy and decision makers owing to significant demographic changes and a care deficit that are forecast to remain long-term challenges well into the 21st century.

Technology has a remarkable capacity to process big data and supplant human beings in the performance of some activities e.g. dispensing medication. Its connectivity also has the potential to enhance some aspects of local communities via social media platforms. However, we must take care with technology and avoid the temptation to think and behave as if technology can take care.

Social interaction, loneliness and related emotions are genuinely experienced by sentient human beings, not by any artificial intelligence. People whose knowledge and skills can be blended with compassion and empathy will therefore remain at the centre of quality of life in healthcare and older adults' care.

Annex 1

Examples of items extracted from version 3 of the UCLA Loneliness Scale[8] are:

- how often do you feel that you lack companionship?
- how often do you feel that there is no one you can turn to?
- how often do you feel alone?
- how often do you feel that you are no longer close to anyone?
- how often do you feel that your interests and ideas are not shared by those around you?
- how often do you feel that you are "in tune" with the people around you?
- how often do you feel left out?
- how often do you feel that your relationships with others are not meaningful?
- how often do you feel that no one really knows you well?
- how often do you feel isolated from others?
- how often do you feel shy?
- how often do you feel that people are around you but not with you?

8 - Russell D. W. (1996), UCLA Loneliness Scale (version 3); Reliability, validity, and factor structure; Journal of Personality Assessment, 66, 20-40

QualityofLifeInstitute@sodexo.com

sodexo
QUALITY OF LIFE SERVICES