Interreg
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EUROPEAN UNION

EUPREVENT | PROFILE
loneliness in older people

EUPREVENT PROFILE

Training Module

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TOPIC 1:

A theoretical section to approach "what is loneliness"

Learning goals:

1. Be able to ask questions about their representations of loneliness and older people
2. Have a better understanding about loneliness
3. Be able to identify the different individual and societal aspects that influence or are influenced by loneliness
4. Be able to identify a person suffering from loneliness

Included sections

1. Representations and stereotypes about older people

In contemporary European and Anglo-Saxon societies, age is the most important factor of discrimination, ahead of gender, ethnicity, or religion (European Commission, Directorate-General for Justice and Consumers, 2015). Discrimination refers to the current negative and predominant view of aging, also called ageism (Adam et al., 2013). Ageism is a term initially proposed by Butler (1969) to designate all forms of discrimination, segregation or contempt based on age. The opposite side of ageism, equally negative, is youthism: the absolute will to stay young ("getting old is not good, and we must do everything to avoid getting old!").

6 This negative view of ageing can occur in surprising ways, for example through the analysis of the content of birthday cards. Researchers have observed that 66 % of messages after 40 years of age show a negative image of aging, under the cover of humorous phrases such as "Once you turn 50, new doors will open for you: geriatric centers and cosmetic surgery institutes", or "Happy birthday! Oh, you're 50? You don't even remember what I'm talking about? Well, happy birthday anyway!") (Ellis and Morrison, 2005). This negative view of aging is also noticeable in English-language repertoire songs (Kelly et al., 2016), Facebook discussion boards (Levy et al., 2014) and Twitter (Gendron et al., 2016), but also through Disney cartoon characters where older people are underrepresented (and when they are, they mostly represent negatively connoted characters) (Robinson et al., 2007).

In continuity of these studies illustrating this ambient ageism, Marquet et al. (2022) asked 81 psychology students from the University of Liege, Belgium, and 155 psychology students from the University of Montreal, Canada, to name the first 5 words that came to mind when they think of an older person and a young. For the entirety of the words collected, they asked judges to rate their values on a scale ranging from -5 (extremely negative) to +5 (extremely positive). Through this process, they were able to create word clouds including the 50 most frequently given words by students (see Figure 1); note that the size of each word is determined by its frequency (the more frequently the word is cited, the larger it is) and the color of each word represents its value (positive, negative or neutral). As we can see, majority of the words generated for the seniors were negative (i.e., 46% of the words for the students in Liege and 48% for those in Montreal). In contrast, very few negative words were generated when they thought of a young person (8% in Liege and 2% in Montreal).

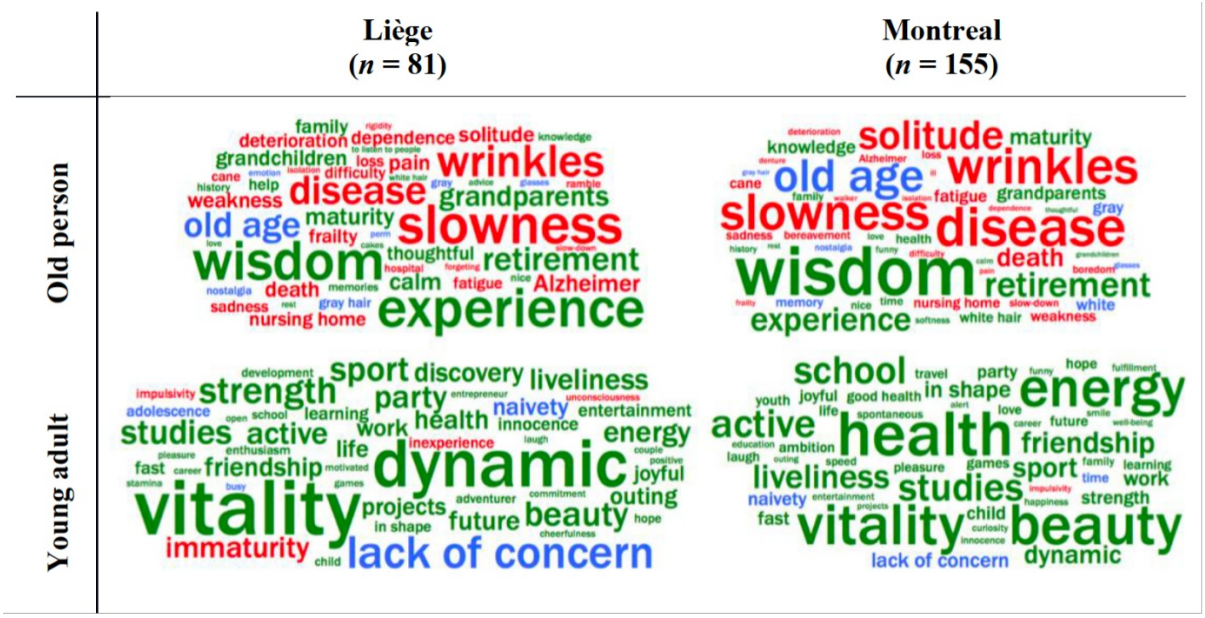

Figure 1: Word cloud of the 50 words most frequently given by psychology students from the universities of Liege (Belgium) and Montreal (Quebec) when they think of a young and an old person. Note that words in red correspond to negative words (-5 to -1); in green, positive words (+1 to +5); and in blue, neutral words (-1 to +1) (Marquet et al., 2022).

While ageism is present in industrial societies, the population of health care professionals deserves special attention. Indeed, these professionals are particularly vulnerable to ageist stereotypes (more so than the general population) since they are constantly in contact with older people in pain. For their majority, this confrontation leads them to consider aging as synonymous with illness, distress, loneliness, or dependence. This "professional deformation" of caregivers was objectified in a survey (Missotten et al., 2016): different categories of caregivers (oncology nurses, staff of institutions for the elderly, and emergency physicians) and non-caregivers (general population) responded to various questions such as "In your opinion, in Belgium, what percentage of people over 65 years of age (1) lives in an institution (Nursing Home/Rest Home), (2) suffers from depression, (3) feels lonely, and (4) has hearing problems?" The answers given by the different categories of respondents were confronted with the "facts", i.e., with data from surveys and/or scientific studies. The result of this comparison is unequivocal: all groups (caregivers and non-caregivers) overestimate the "facts" for all parameters. However, this overestimation appears systematically more marked among caregivers than among non-caregivers (see Figure 2). This survey was executed before COVID-19: however, the prevalence of loneliness (19%) (Busschaert et al., 2020) after COVID-19 is still highly overestimated.

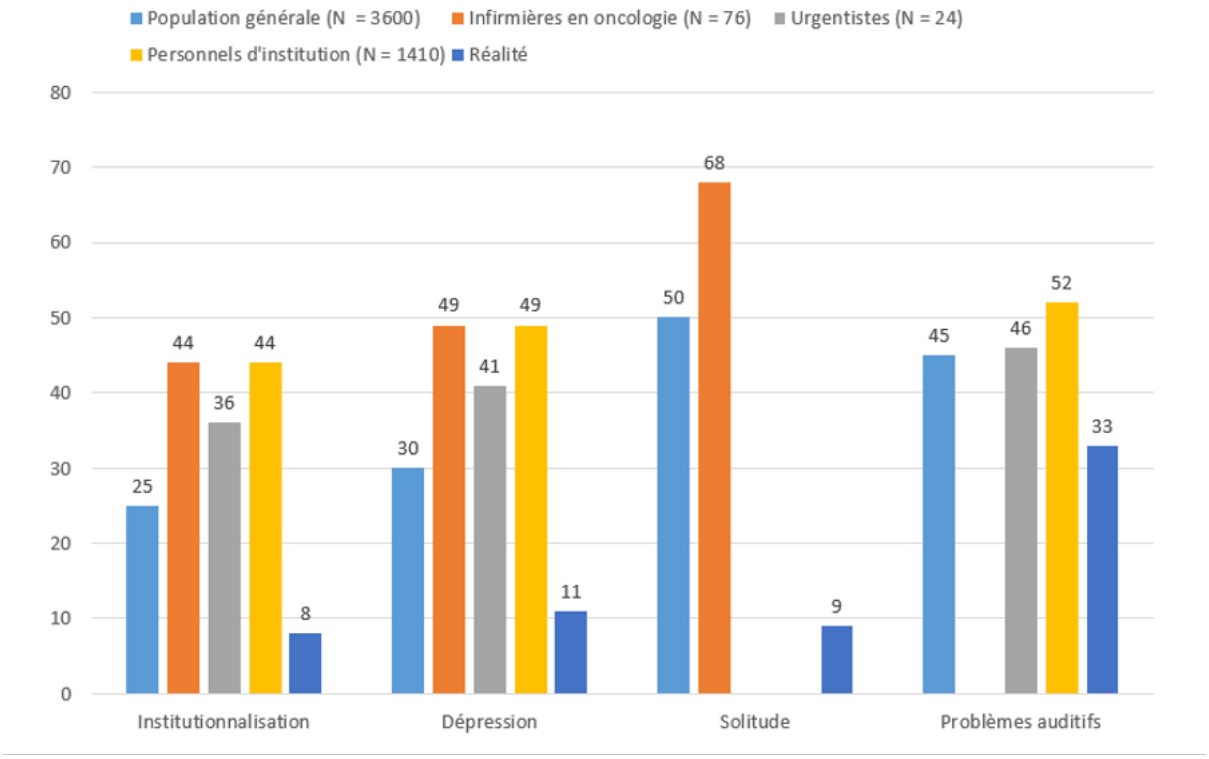

Figure 2. Estimated percentage of people over 65 in Belgium who are institutionalized, suffer from depression, feel lonely, and have hearing problems with contrast caregivers vs. non-caregivers (Missotten et al., 2016).

Ageism is not without consequences for the elderly: among other things, an abundant literature underlines its deleterious effects on the physical and mental health of seniors. For example, in a series of longitudinal studies (in other words, where the same people are followed during several years) addressing the consequences of representations of aging in older subjects (without any pathology such as Alzheimer's disease), Levy's team (see Levy, 2009 for a summary) showed that individuals with an initial negative view of aging are and report being in poorer physical health in the years that follow (up to 28 years later), engage less in preventive behaviors (playing sports, eating healthily, quitting smoking, etc.), develop more cardiovascular problems, have a higher risk of heart disease and stroke, and have a higher risk of death), develop more cardiovascular problems, show a more marked memory decline, and have a lower life expectancy (about 7.5 years less), compared to individuals of the same age with a more positive initial perception of aging. These different studies demonstrate the effect of stereotype internalization ("stereotype embodiment theory") (Levy, 2009): in other words, the stereotypes that integrated throughout the course of life become part of each person's identity and therefore influence their functioning and their health. Older people may therefore internalize the stereotype of loneliness and, with advancing age, feel lonelier than those who would not have internalized this stereotype (Shiovitz-Ezra et al., 2018). Pikhartova, Bowling and Victor (2016) demonstrate this effect: people who

expect to become lonelier with advanced age or who have the stereotype that old age is a time of loneliness, become lonelier several years later. Another hypothesis is social rejection: discrimination against older adults could result in their progressive withdrawal from social participation and growing feelings of loneliness. Thus, after experience situation of social rejection, older people tend to isolate themselves voluntarily, which gradually creates a feeling of loneliness (Shiovitz-Ezra et al., 2018).

2. What is loneliness?

Loneliness could be viewed as a unidimensional or multidimensional concept (Ong et al., 2016). Generally, it is defined as the discrepancy between a person's preferred and actual level of social contact (Ong et al., 2016). The multidimensional concept distinguishes two kinds of loneliness : (1) relational (or social) loneliness, which is associated with a small social network, and (2) emotional loneliness, resulting from the lack of an intimate relationship (Heinrich and Gullone, 2006; Ong et al., 2016). With this perspective, a definition of loneliness could be a "subjective negative feeling associated with a perceived lack of wider social network or absence of a specific desired companion" (Valtorta and Hanratty, 2012).

Furthermore, it is important to distinguish loneliness from social isolation: loneliness could appear without social isolation and social isolation does not lead directly to loneliness (Bultez, 2005). Indeed, loneliness is a subjective feeling related to the unpleasant lack of relationships whereas social isolation is objectified by the frequency of contacts (Ong et al., 2016). Some studies use the term "perceived social isolation" to refer to loneliness (Cacioppo and Hawkley, 2009). Similarly, researchers distinguish loneliness from solitude: the latter is a voluntary social isolation whereas loneliness is involuntary (Ong et al., 2016). Contrary to loneliness, solitude may have positive cognitive benefits such as enhancing concentration, learning, self-reflection, creativity etc. (Heinrich and Gullone, 2006).

3. Correlates of loneliness

Several factors have been found to be associated with loneliness, whether more causal or consequential. We refer to these as correlates. These correlates are broadly categorized into: (B1) demographic factors; (B2) health factors, including physical, mental, cognitive health; and brain, biology, and genetics; and (B3) socioenvironmental factors, including digital communication; and the workplace (Lim et al., 2020).

A) Demographic factors:

This group/category includes age, gender migration, living and socio-economic status (Lim et al.,

2020).

- Age: Previous studies show that loneliness follows a U-shaped distribution. This means that loneliness shows to be most prevalent in young adults between the ages of 18-25 years, plateaued in middle adulthood and peaks again at 65 years for older adults (Hawkley et al., 2022; Lim et al., 2020). The peak age for older people is not consistent in the literature : other studies noticed a peak in people over 85 years old and not at 65 years of age (Hawkley et al., 2022; Lasgaard et al., 2016; Pinquart and Sörensen, 2001). Moreover, authors explain the decrease of loneliness for people under 85 years old by the socioemotional selectivity theory and/or a cohort effect (Pinquart and Sörensen, 2001). First, according to the socioemotional selectivity theory, aging leads to a significant subjective feeling that the time left is limited (Carstensen, 2006).Therefore, people are more focused on the present : they prefer to live in the moment, invest in safe things and choose deeper relationships (Carstensen, 1995). Consequently, older people tend to focus on the quality of their relationships instead of extending their social network (Carstensen, 2006). Concentrating on the quality of the relationship is more likely to reduce feelings of loneliness (Pinquart and Sörensen, 2001). Secondly, a cohort effect is hypothesized: older generations have life experiences with important losses (for example, world wars) and so difficulties related to aging may seem less serious in their point of view. Another explanation could be that their generation is less inclined to self-disclosure (and so to acknowledge feelings such as loneliness) (Pinquart and Sörensen, 2001). In comparison, the increase of loneliness in oldest-old people is explained by the existing social losses (such as widowhood, mourning of friends...) and physical limitations (for example sensory deficits that can limit communication) that amplify their social needs and so, even a minimum of social contacts is difficult to be attained (Pinquart and Sörensen, 2001).
- Gender: loneliness is more prevalent in women than men either in young or older adults. However, the way that loneliness was measured should be taken into consideration. When asked "are you lonely?" older women report higher levels of loneliness when compared with older men. When asked indirectly (e.g., "I miss having people around me"), older men reported high levels of loneliness. Whereas the implementation of different measurement tools yield no differences in the severity of loneliness among younger males and females. Unique predictors of loneliness for women in comparison with men, can also occur (Lim et al., 2020).
- Marital status: Feelings of loneliness are more often reported by unmarried people than those who are married. Loneliness is most prevalent in widowed individuals, followed by divorced and unmarried (Lim et al., 2020).
- Living status: Living alone is associated with higher levels of loneliness. However, those who are living in assisted living environments (e.g., nursing homes) are lonelier when compared with community dwelling older adults (Lim et al., 2020).

- Socio-economic status: The is limited evidence for the impact of socio-economic status on loneliness. Lower income, lower educational level, the frequency of economic problems, and living in poor neighborhoods are associated with higher levels of loneliness (Lim et al., 2020).
- Migration status: Migrants reported being more lonely than non-migrants. Migrating to a country with a different cultural context than one's homeland was associated with being lonelier (Lim et al., 2020).

B) Health

- Physical health : A high feeling of loneliness has been linked to bad health outcomes, such as poorer physical health (Holt-Lunstad et al., 2015; Ong et al., 2016): higher mortality and morbidity rates, poor sleep, and increased cardiovascular reactivity (higher cholesterol, blood pressure, heart disease) are correlated with higher levels of loneliness. Concerning the mortality risk, a meta-analytic review found that when feelings of loneliness occurred, the increased likelihood of death was at 26% (Holt-Lunstad et al., 2015). Indeed, the researchers found that the heightened risk for mortality from a perceived lack of social relationships was greater than the mortality risk due to obesity. More specifically, for older adults, loneliness is associated with impaired daytime functioning, reduced physical activities, lower subjective well-being, poorer physical health and mortality (Luo et al., 2012; Ong et al., 2016). It is worth mentioning that the impact of loneliness on mortality is less important when aging: middle-age adults are at greater risk (Holt-Lunstad et al., 2015). Especially in later adulthood, loneliness has been severely associated to sleep disturbances: poorer sleep quality, shorter sleep duration and diminished sleep efficiency (Lim et al., 2020; Ong et al., 2016). Furthermore, loneliness has been linked with breast- and colorectal cancer, as well as multiple sclerosis for people aged 50 years old and above (Lim et al., 2020).
- Health-risk behaviors : Loneliness has been found to be associated with an unhealthy lifestyle (Pressman et al., 2005). Indeed, people who are experiencing loneliness are more likely to smoke, drink alcohol, have a poor nutrition and reduced physical activity (Ong et al., 2016; Sutin et al., 2018). These health behaviors may partly explain the increased risk of mortality among lonely people.

- Mental health: Previous studies showed that higher levels of loneliness are associated with more severe mental health symptoms, including higher social anxiety, depression, lower subjective well-being (Ong et al., 2016) and psychotic symptoms such as paranoia. Furthermore, poorer emotion regulation is also associated with higher levels of loneliness (Lim et al., 2020), indicating that people with higher levels of loneliness are less likely to express positive feelings, to enjoy positive moments or to recall positive life events (Lim et al., 2020). In other words, there is a bigger sensitivity to negative social stimuli (Ong et al., 2016).

Moreover, there is a significantly positive correlation between levels of loneliness and depression among elderly adults (Elsayed et al., 2019). In the overview of Leigh-Hunt et al. (2017), a reduced sense of belonging was associated with increased risk of suicidal ideation and attempts, at all ages. More specifically, among elderly people, the level of social integration had an influence on non-fatal suicidal behaviors.

Emotional loneliness has been found to impact health more than social loneliness. Emotional loneliness is linked to anxiety, hypervigilance and feelings of abandonment, whereas social loneliness is associated to boredom, depression and lack of purpose (O'Súilleabháin et al., 2019).

- Cognitive health : Increased loneliness is associated with accelerated cognitive decline (Boss et al., 2015; Lim et al., 2020), which has an influence on the ability to function independently on a daily basis. In a systematic review, Boss et al. (2015) showed that loneliness can generate problems in various cognitive domains such as general cognitive ability, IQ, processing speed, immediate and delayed recall. Persistent loneliness has also been associated with impaired executive functioning and a lower capacity of trusting others (Ong et al., 2016). Sutin et al. (2018) explained that poor health behaviors and bad physical health outcomes are also implicated in dementia risk. Indeed, people with higher levels of loneliness are 64% more likely to develop dementia than their counterparts (Lim et al., 2020). Furthermore, cognitive decline such as decreased verbal fluency may lead to greater isolation and subsequently, for some people, greater loneliness.
- Brain, biology, and genetics: Studies concerning loneliness in human primates show that it activates neural regions involved in threat detection, attention, and emotion processing. Higher levels of loneliness are also shown to be associated with structural changes of grey and white matter as well as altered functional and structural brain connectivity. Loneliness is also associated with increased circulating cortisol and twin/adoption studies also suggest that feelings of loneliness may be partially predetermined by genetics (Lim et al., 2020), meaning that some genes could have an influence on the perceived level of loneliness. Higher levels of loneliness also appear to be linked with increased vascular resistance (Luo et al., 2012), altered immunity (decreased production of natural killer cells) and a higher inflammatory response to acute stressors. Loneliness can impact health, by, for example, modifying the acute stress reactivity response (Holt-Lunstad et al., 2015). This increased inflammation in lonely people may be a pathway for impaired cognitive functioning, knowing that inflammation is involved in pathological processes that are implicated in Alzheimer's disease and dementia (Boss et al., 2015). Moreover, loneliness activates hypervigilance for social threats existing in the environment and this chronic activation diminishes the executive functioning and enhances

the likelihood of the person to engage in self-control health behaviors (Luo et al., 2012). This is demonstrated in a metanalysis done by Brown, Gallagher and Creaven (2018), which showed that for most people, higher levels of loneliness are associated with exaggerated physiological reactions in stressful situations, for example public speaking or cognitive tasks. Also, specific parts of the brain, involved in reward processing and learning (ventral striatum), is less activated in lonely people when looking at images of strangers in pleasant social situations, in comparison with those who are less lonely (Lim et al., 2020).

4. How to identify someone who feels lonely?

Identifying whether someone feels lonely is not always straightforward. Several methods exist to assess whether someone feels lonely. The most common one is a one-item question ("Do you feel lonely) (Ong et al., 2016). However, it can lead to gender biases in older populations: by using direct questions, older women reported a higher level of loneliness than older men (Lim et al., 2020). Furthermore, a single item question assumes that the respondent has a general understanding of the term/concept of loneliness (van Tilburg, 2021). Among the existing scales, the two most frequently used are the UCLA loneliness scale and the de Jong Gierveld loneliness scale (Ong et al., 2016).

- The UCLA loneliness scale consist of 20 items (e.g., "There are people who really understand me", "I feel part of a group of friends") and participants are asked to indicate how often they experience the feelings described (1 = never, 2 = rarely, 3 = sometimes and 4 = often) (Russel, 1996). It conceptualizes loneliness as a unidimensional emotional response (Penning et al., 2014). A 3-item version has recently been developed: "How often do you feel that you lack companionship?"; "How often do you feel left out?" and "How often do you feel isolated from others?" (Hughes et al., 2004).

Statements	Never	Rarely	Sometimes	Always
How often do you feel that you are "in tune" with the people around you?				
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 part of a group of friends?				
How often do you feel that you have a lot in common with the people around you?				
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 outgoing and friendly?				
How often do you feel close to people?				
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 that you can find companionship when you want it?				
How often do you feel that there are people who really understand you?				
How often do you feel shy?				
How often do you feel close to people?				
How often do you feel that people are around you but not with you?				
How often do you feel that there are people you can talk to?				
How often do you feel that there are people you can turn to?				

Three versions exist (1978, 1980 and 1996): all are 20-items but the phrasing differs.

- The second scale, De Jong Gierveld scale, explores emotional loneliness (e.g., "I experience a general sense of emptiness") and relational loneliness (e.g. "There are enough people I feel close to") with 11 items. Respondents have to indicate at which extent the statement presented applies to the way they feel at the moment (five modalities : yes!, yes, more or less, no, no!) (Penning et al., 2014). A shorter 6-item version has also been developed (Gierveld and Tilburg,

2006). Other researchers support the use of these scales for middle-aged and older adults (Penning et al., 2014).

Statements	Never	Rarely	Sometimes	Always
There is always someone I can talk about my day-to-day problems				
I miss having a really close friend				
I experience a general sense of emptiness				
There are plenty of people I can lean on when I have problems				
I miss the pleasure of the company of others				
I find my circle of friends and acquaintances too limited				
There are many people I can trust completely				
There are enough people I feel close to				
I miss having people around me				
I often feel rejected				
I can call on my friends whenever I need them				

Regarding the scores obtained on the scales, it is important to discuss and interpret them according to the current context and environment of the person. If the person shows a high score and has recently lost their partner, the loneliness experienced will seem more understandable than if the respondent is a person with chronic loneliness.

Here are some common signs of loneliness to look out for (WaveLength, n.d.):

a) Spending much time alone:

It's the most obvious one: a person who seems to spend a lot of time alone could be a sign of loneliness. For example, if they don't want to see anyone or want to stay in their room all day long, it could be because they are nervous about seeing people. Of course, it's not the case for everyone who spends time alone – some people simply enjoy their own company.

b) Being non-productive:

Because of loneliness, some elderly people might lose interest or might struggle to feel inspired by their previous source of interest.

c) Dwelling on the negative points:

Feeling lonelier can be associated with being annoyed by the smallest things and linger on their bad experiences. It could be explained by the fact that the person who feel lonelier don't have a close friend to laugh it off with.

d) Seem to be often sick:
Tiredness and frequent illnesses can be signs of several things (including an underlying health issue) and not loneliness. However, people who feel lonely are more likely to experience disturbed sleep. We also know that it can be difficult for their immune system to fight of smaller illnesses (like coughs and colds) due to their increased stress levels.

e) Seem to give too much importance to their possessions or hobbies:
When someone experiences loneliness, this person is more likely to try to distract themselves with other things in their lives. Spending too much money on unnecessary thing can be a sign because loneliness can also lead to increased consumerism.

Not everyone who spends time alone is lonely. It's important to have a discussion with the person to know if this is the case.

5. Influence of COVID

A recent and important trigger of loneliness relates to the COVID-19 pandemic. In Belgium, a survey has shown that one out of four older adults experiences an increase of loneliness during this period (AGO, 2020). Similar results have been found in another Belgian survey, carried out between September and November 2020, showing that in comparison to 2017 the loneliness has increased: for people aged of 60 years old and more, 3% declared a feeling of loneliness each day in 2017 whereas 5% declared it in 2020 (Busschaert et al., 2020). A survey concerning the consequences of COVID-19 executed in Wallonia amongst 1082 nursing home residents showed that 17% of them declare a feeling of loneliness (Adam et al., 2020). In a study realized in the United States among 1.545 adults (18-98 years old), results showed an increase of loneliness only among individuals over 65 years old in late March and April (after the social distancing orders) compared to late January (Luchetti et al., 2020). On the other hand, another study with 1.141 participants of more than 50 years old (mean age of 67 years old), observed an enhancement only of social isolation and not of loneliness (Peng and Roth, 2022). Others suggested that and increase was observed buy only for people who already suffered from loneliness before the pandemic (Creese et al., 2021). Summarized, loneliness in older people seems to be a collateral damage of the pandemic (Dahlberg, 2021; van Tilburg et al., 2021). Nevertheless, it is also important to highlight the capacity of older adults of showing resilience during this situation: indeed, they seemed to be less psychologically impacted in comparison to younger adults (AGO, 2020; Birditt et al., 2021).

Raising awareness on the importance of self-care in order to reduce feelings of isolation and anxiety, is essential in promoting well-being for everyone. In support of this effort, a website was

developed by the University of Tulane (USA) and dedicated to self-care tools and resources ("Self-Care Tips from Tulane University School of Social Work," n.d.), in order to provide easy access to tools across the main self-care areas of meditation/mindfulness, physical activity, social connectedness, and indulging/fun activities.

Literature suggests that social support is not only important for reducing negative symptomatology but also for promoting positive adaptation following the COVID-19 crisis. Associations between loneliness and neighborhood perception (Matthews et al., 2019) may also influence post-pandemic mental health, yet we may also see improved social cohesion, similar to studies following the SARS epidemic in 2003 (Lau et al., 2005). The wide access to technology is unique to the COVID-19 crisis and can help buffer loneliness and isolation that can lead to exacerbated mental health problems (Smith et al., 2018). Similarly, the importance of social networks has been demonstrated in the literature, promoting resilience to stress and trauma.

6. Particular life events

Some life events can increase the likelihood of feeling lonely.

- For example, retirement is an important period of change. Therefore, for people who already suffer from loneliness, the risk of depressive symptoms is higher after retirement (Segel-Karpas et al., 2018). Also, involuntary retirement is associated with higher loneliness (Shin et al., 2020).
- Bereavement is a very powerful trigger (Robertson, 2019). There is an increased risk of death following the loss of a spouse: 13.1% of men and 7.4% of women between 80 and 84 years old deceased within the year after the loss of their spouse. The higher risk of death for men can be explained by the presence of more risky behaviors such as alcohol consumption or suicide (Guilbault et al., 2007). Following the bereavement, a period a readjustment occurs and a decline of loneliness is observed : this can be due to getting used to living alone or to a readjustment of social expectations (Utz et al., 2014).
- The specific situation of nursing homes deserves a particular attention. Indeed, if we can naively think that residents have fewer risks of feeling alone given that they live in community, a meta-analysis concluded that 61% of residents have a moderate feeling of loneliness, and 35% a severe one (Gardiner et al., 2020). A previous research comparing community-dwelling people (n = 234) with nursing home residents (n = 234), showed that institutionalization has a strong effect on loneliness (Prieto-Flores et al., 2011). A study conducted in Norway on 225 older individuals without any cognitive impairments and living in nursing homes showed that emotional closeness to significant others is more important in order to explain feelings of loneliness, whereas the frequency of contacts with family and friends is not (Drageset et al.,

2011).

- Another point of attention concerns informal caregivers (for example spouses of people with neurodegenerative diseases or chronic illness such as cancer). Indeed, one important challenge they are facing is loneliness (Vasileiou et al., 2017). The prevalence of moderate loneliness among caregivers of adults with dementia is 43.7%, and for severe loneliness 17.7% (Victor et al., 2021). Previous research has showed that when comparing caregivers with non-caregivers, the score of loneliness is higher for caregivers (Beeson, 2003). This feeling could emerged by example by diminished social interaction, shrunken personal space, feelings of powerlessness and sole responsibility (Vasileiou et al., 2017).

- Furthermore, people living with dementia are also at risk of experiencing loneliness. Victor et al. (2021) conducted a study in the United Kingdom, trying to establish the key predictors and the prevalence of loneliness among people living with mild to moderate dementia (n = 1547). One-third of the participants reported experiencing moderate loneliness and 5% of them reported severe loneliness. In this study, depressive symptoms and increased risk of social isolation were both associated with moderate and severe loneliness. Living alone and reporting a poor quality of life, poorer life satisfaction and well-being were also related to greater risk of severe loneliness. However, dementia diagnosis was not associated with loneliness, nor was cognitive functioning.

  On the other hand, a Swedish study (n = 589) about loneliness and cognitive functioning among elderly people found that people living with dementia were significantly more likely to experience social loneliness than those without dementia. Indeed, in their study, social loneliness increased with reduced cognitive functioning, which shows the importance of having a meaningful social network. However, no differences were observed regarding the emotional experience of loneliness (Holmén et al., 2000).

  An experiment conducted by Opdebeeck et al. (2021) showed that owning a pet can reduce loneliness, for those who like having animals. It can decrease the stress that follows the loss of a loved one and depression through companionship and purpose, but it's not always the case. In their research, they studied the relationship between self-reported pet ownership and pet care with loneliness, physical activity, depression and quality of life in people living with dementia. People with mild to moderate dementia who owned a dog were less likely to feel lonely than those with no dog, indicating that taking care of a pet can decrease feelings of loneliness. However, they also found that having a pet but not being involved in the care was associated with greater depression and decreased quality of life in comparison with people that did not own a pet. To sup up, the involvement of the person with dementia in the care of their animal was a key factor in the associations.

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TOPIC 2:

A section on practice and how to address loneliness with lonely people

Learning goals:

1. Be able to communicate with a person about her loneliness
2. Be able to intervene appropriately with a person who feels lonely / be aware of the different approaches available to help a person who feels alone ?
3. To know about possible preventive actions

Included sections

1. How to communicate with a lonely person about her loneliness and how to build trust

When communicating with a person who is possibly lonely, building and maintaining a connection is more difficult than with a person who is not lonely (Schoenmakers, 2020). This difficulty may be related to the social skills of the person who is feeling lonely (Jin and Park, 2013). Lonely people seem to be less comfortable with conversational skills, for example they interact less with others (Bell, 1985), and also may consider themselves less capable of communicating with others (Spitzberg and Canary, 1985). This may lead to feelings of being trapped in a vicious circle: feeling less capable of good conversation, intervene less frequently in exchanges, which can lead to lower quality social relations (Rotenberg et al., 2002). These experiences may result in avoiding social situations (Cacioppo et al., 2006), reinforcing their image of being unable to hold a good conversation. Being able to get "inside the bubble" of the person experiencing loneliness will not always be easy as these people are likely to avoid contact or not be comfortable in conversation. A relationship of trust and patience is therefore essential.

Once contact has been established, it is not easy to talk directly about loneliness (Schoenmakers, 2020). Indeed, people may feel a certain shame and may avoid talking about it, notably for fear of a negative reaction. It is not uncommon for people who do not feel lonely to blame those who do (Hauge and Kirkevold, 2010). It is therefore important to be able to break the taboo (Michiels & De Wachter, 2019). To do this, it is advisable to approach it not as something difficult but as a normal topic of discussion, taking away the stigma and taboo. Having an open perception towards loneliness can be considered essential (Baftehchian, 2021).

When the subject of loneliness is addressed and discussed, the mistake would be to want to quickly propose solutions/explanations before establishing an authentic relationship (e.g.: "to feel less lonely, you have to go out", "don't think about the past", "look at the good side of things"...). These attitudes, while intended to be helpful and caring, are rarely effective. When we talk about difficult subjects, we also sometimes tend to want to reassure the person (e.g., "it will be fine, I'm sure it will get better, you still have your children coming to see you..."). However, this tendency to reassure is sometimes counterproductive: it sends the message that the drama that the person is experiencing is not necessarily a drama, to make him understand that what is for him 'serious', 'terrible', 'horrible', 'screwed up', is not as serious as he claims (Delvigne, 2021a). When you as a carer want to reassure the person, an important question to ask is: "Who am I trying to reassure? Is it really the person I am helping or am I trying to reduce my discomfort with the person's distress?

Therefore, when dealing with a subject such as loneliness, what is more important is that the person feels that we believe in him or her, in his or her abilities and skills (Delvigne, 2021b). This

brings us back to the importance of the quality of the relationship, of the trust that can be established. According to Carl Rogers, an American psychologist of the 50's, this relationship would even be the main engine of help (Delvigne, 2021b). He identified three main elements to make this relationship a quality one: (1) the caregiver's capacity for empathy, (2) unconditional positive acceptance and (3) the caregiver's authenticity.

First of all, empathy means understanding. To show empathy is to show an intimate understanding of what the other is experiencing. This implies an intimate understanding of what the other person is feeling, seeing, experiencing, thinking, judging, interpreting, etc. (Delvigne, 2021b). The mistake would be to try to put oneself in the place of the person: for example, if I feel lonely, I like to go out and take my mind off things and I think that the person should do the same. So, it's not about doing "as for me" or "as for my parents" but about understanding what the person in front of me is experiencing. In order to show empathy, 5 skills are generally described (Maeker and Maeker-Poquet, 2020): (1) the willingness to establish an interpersonal relationship: in other words, our engagement in the relationship with the other as an equal. As a caregiver, a mistake would be to see ourselves as the "expert" who has the solutions and must therefore pass them on: the person is the expert of his or her experience; (2) non-judgment: this consists of avoiding categorizing, labeling (e.g., considering all people as a homogeneous group) or moralizing (e.g., "if you feel lonely, why don't you go out?"); (3) active listening: for example, using "reflections. This can be a simple rephrasing of what the person has just said (e.g., "you think you are a burden") or a proposal that summarizes what he or she said (e.g., "so you have the impression that no one is really available to you, that you give a lot to others without receiving anything in return"); (4) non-verbal communication: the look, the facial expressions, the gestures, the body posture, the touch, the physical distance between the two bodies, etc. (4) Emotional intelligence: naming one's emotions correctly and being able to control them, in order to avoid emotional or professional exhaustion).

The second element for a quality relationship according to Carl Rogers would be unconditional positive acceptance, which consists in accepting the person's experience, unconditionally, without trying to change it. In other words, I am not trying to remove the sadness, make them feel less at fault, etc. Wanting to change someone's state of mind is really a non-acceptance of the other person's experience. If I want her not to be sad anymore, it shows my inability to accept this sadness. However, if the objective is to encourage openness to one's experience, we should start by accepting ourselves, calmly, what the person is experiencing deep inside (Delvigne, 2021b).

Finally, caregiver authenticity refers to the caregiver's ability to access his or her own experience, to identify his or her internal movements and, if necessary, to communicate them.

This means being aware of what we are experiencing at the very moment we are experiencing it, of what we are thinking at the very moment we are thinking. If only to interrupt this action once we are aware of it, rather than letting ourselves be carried away by it. Moreover, insofar as help consists of encouraging the "opening" of consciousness in the other, by the other, this work of conscientization and acceptance is facilitated by the "opening" that we give to see our own internal movements. What I propose to the other, I apply to myself in a way. Finally, this authenticity of the caregiver gives the relationship a certain depth, a certain consistency. We drop the mask. We break the ice. We don't hide. You don't play a role (Delvigne, 2021b).

2. Concrete tools to discuss loneliness

From Crossed Words

"Motus, des images pour le dire" (Le Grain / Question Santé) is a symbolic language game for leading a discussion with a group; it facilitates exchange among participants and oral expression. Thanks to a set of 280 symbolic images, this tool organizes the right to speak in an equitable manner, it tempers the talkative and helps the silent to express themselves. Different variants are proposed according to the desired goal (https://questionsante.org/outils/motus/).

("Motus," 2010)

“Isolitude”

a facilitation tool that opens a dialogue on loneliness and isolation within adult groups. This tool consists of an animation guide and a deck of cards, designed for a group of 5 to 12 people, lasting a minimum of two hours (https://www.cultures-sante.be/nos-outils/outils-education-permanente/item/435-isolitude.html).

(“Isolitude,” 2017)

"How are you doing?"

A Red Cross card game to express oneself and become aware of one's emotional state as well as one's strengths and weaknesses, in order to overcome challenges together. Online or physical (https://covid.croix-rouge.be/et-toi-comment-tu-vas/particuliers/).

("Et toi, comment tu vas," n.d.)

Feelin' Cards

The Feelin' Cards was created by Marie Edery and Anna Edery. Each card represents an emotion, mood or feeling illustrated in a funny and expressive way. These 52 "emojis" have been created especially for this game, which is intended for adults and professionals as well as for children. The Feelin' Cards are intended for everyone and must remain open to the elaboration of the person who draws them. On a personal level: to make people think or to amuse them. How are things going? What's going on inside me? At the moment? Over time? Within the framework of an animation: icebreaker, emotional diagnosis of a team, tension management, mediation, motivation, discerning hidden needs, etc. Within the framework of an individual coaching: to make the person talk about himself, his context of the day or a professional situation (https://www.furet.com/livres/feelin-cartes-comment-ca-va-aujourd-hui-laissez-parler-vos-humeurs-et-emotions-marie-edery-9782491869090.html).

("Feelin' cartes, comment ça va aujourd'hui ?," 2022)

Inspiratiekaarten (ENG: inspiration cards)

This card set includes 49 color inspiration cards with the aim to discuss life themes with co-workers or clients. These cards are intended to be used in conversations with two persons or group meetings. The card set is not for free and can be ordered the website (https://www.jewereldinzicht.nl/shop/inspiratiekaarten/)

(taken from the website)

Levensluister

Levensluister aims at listening about the life of an older person. For this, a set of cards was developed, comprising in-depth questions about someone's life throughout all the life phases. These cards are meant as a tool to start an in-depth conversation. In addition to this card set, it is possible to follow a workshop. The set of cards can be ordered from the website (https://levensluister.nl)

(taken from the website)

Extension set loneliness

This card set is developed by The bagagedrager in co-production and can be seen as an extension to the boardgame 'een steekje los', but can also be played without this board game. This set contains 110 cards that can be used to start conversations about loneliness, but also as a communication tool at educational meetings. The board game and/or card set can be ordered at the website. (https://debagagedrager.nl/product/uitbreidingsset-eenzaamheid/)

(taken from the website)

Kletsborden

Kletsborden is a boardgame to promote real contact, in which everyone can participate in his/her own way. In this game, participants share their stories and ask each other questions. This game is suitable for young and old and can be ordered online. Furthermore, this game can also be played online (https://www.kletsborden.nl)

(taken from the website)

3. How to promote actions

To motivate the person to move forward, exercises can be done with the person:

Ex 1: Make a list of the pros and cons of moving forward (Nezu and Nezu, 2018):

- Make two columns
- List the benefits and costs of doing nothing (left column)
- List the benefits and costs of moving forward (right column)
- Compare all consequences
- Consider the short- and long-term consequences for yourself and others
- Place this sheet in a visible location
- Compare the two columns and think about the best solution: do nothing or go ahead

Ex 2: Projecting yourself into the future, visualizing the problem solved (Nezu and Nezu, 2018). This is the technique used by Dr. Frankl imprisoned in a Nazi camp: while on a forced march, sick, tired, hungry, bereaved... he felt exhaustion and a lack of hope. He fell and knew that if he did not get up, he would be killed. He then projected himself into the future, using his imagination: he saw himself at the university, giving a lecture and explaining how he had survived the camp. This gave him enough courage to get up and continue.

Ex 3: Practice behavioral activation, which is originally advocated in the treatment of depression but can be applied in the context of loneliness, where people will often show immobility. The more activated I am, engaged in activities where I feel pleasure/control, the less depressive symptoms I experience.

- Step 1: Think about your personal values and the activities you are still doing, and rate the pleasure you get from them, the importance of the activity to you and your sense of control, from 0 to 10
- Step 2: Identify abandoned/new activities that would be related to the values and areas of life stated as important, then rank them from easiest to most difficult to accomplish
- Step 3: Plan an activity that the person qualifies as "easy to do," such as an activity the person was doing before and enjoyed doing. The purpose of the action? To refocus on our values, that is, what really matters to us. The more we engage in activities that are consistent with our values, the greater our motivation to engage in such activities.
  - Where, when, how, with whom will I need outside help?

4. What interventions exist?

Interventions to loneliness can emerge at four levels: individual, relationships, community and

societal. Of course, interactions exist between levels and each intervention could be examined within each level (Lim et al., 2020).

Individual level

As multiple factors influence loneliness, solutions should be relevant to the unique experience of the person to be effective: we need to understand the individualized experience of loneliness and identify barriers that the individual faces (Lim et al., 2020).

Nevertheless, in a global way, several interventions to reduce loneliness in an individual way has been developed. A meta-analysis identifies two strategies specific to loneliness (and not social isolation) (Masi et al., 2011):

- Improving social skills (e.g., improving conversation skills);
- Addressing maladaptive social cognition through cognitive behavioral therapy (Masi et al., 2011; Ong et al., 2016). The last strategy seems to have larger effect size. To address maladaptive social cognition, programs used for example cognitive behavioral therapy: they teach lonely people to identify automatic negative thoughts and regard them as hypotheses rather than facts (Masi et al., 2011). In order to change the person's relationship with their loneliness, the acceptance of the feeling can also be worked on. This can be achieved through welcoming meditation, mindfulness exercises, etc. Bringing a person to acceptance increases his or her sense of control over his or her own life, decreasing dependence on others (Baftehchian, 2021).

Moreover, these last years, a specific point of interest was given to new technologies: a meta-analysis indicates good results of computer and internet programs and suggest their use for older adults. Indeed, it allows to reinforce existing social network as well as find social activities (Choi et al., 2012).

Relationships and community level

Concerning community-based solutions, we can find for example some initiatives with the aim of bringing networks to people (for example weekly phone calls and home visits to lonely older adults) (Lim et al., 2020). A major element is to establish contact between people. Of course, not all contacts is positive and some recommendations has been underlined for institutions who want to bring people together (Yates, 2015) : (1) equality : it is important that nobody feels superior or inferior to others; (2) commonality: be part of a common project; (3) inclusivity : accessible to multiple groups (not be perceived as exclusive but attractive to multiple segments of a population).

To initiate contacts between people, a specific point of interest concerns intergenerational programs. A review highlights the fact that these programs are beneficial for older adults (even with cognitive impairment) as well as children (Gualano et al., 2018). A lot of intergenerational programs has been developed (Hatton-Yeo and Ohsako, 2000): sometimes young people help older people, sometimes it is the opposite (for example, older people are reading books to children (Murayama et al., 2015)) and sometimes both generations work together (for example in a theatre group). In a global way, in all intergenerational programs, a specific attention is required to the risk of infantilization : a theoretical framework is needed for the implementation of such programs as well as a well trained staff (Gualano et al., 2018).

Societal level

Finally, among interventions to reduce loneliness on the societal level, we can cite educational public awareness campaign to increase awareness of loneliness and promote positive social behaviors (for instance, Canada develops a campaign to invite people to connect with an older one) (Lim et al., 2020). Concerning interventions designed for older people specifically, a review of literature in 2003 concludes that the evidence for effectiveness of such interventions are very little (Findlay, 2003). This lack of evidence could be due to the methodological difficulties (recruitment of lonely older participants). A critical review, analyzing studies between 1996 and 2011, suggest efficient reduction of loneliness by educational interventions, focus on social network maintenance and enhancement (Cohen-Mansfield and Perach, 2015).

In a global way, many interventions to reduce loneliness among older people have been developed but we cannot develop a standardized approach, suitable for everyone: interventions have to be individualized or adapted to specific groups (depending on the context, the population, the degree of loneliness...) (Fakoya et al., 2020). It must addresses the specific causes of loneliness (Fried et al., 2018). It has to take into considerations loneliness as a heterogeneous construct and target individuals' needs ("Why Loneliness Interventions Are Unsuccessful," 2020). More than just connecting people between each other, interventions need to address the "internal" (emotional experience), as well as "external" (connecting people) aspects of loneliness' experience (Robertson, 2019). The failure of current approaches, therefore, lies not in the interventions per se, but in the lack of integration and adjusting particular interventions to "the right person, at the right time" ("Why Loneliness Interventions Are Unsuccessful," 2020).

5. How to identify the needs of the person and how to handle them

The main element of identifying a person's needs is to take time to talk with them. Taking time will help to determine if actions are necessary and possible, and if so, which ones are

appropriate for them. Loneliness is an individual and subjective experience, so it is important to be able to build on the person's own needs, experiences, emotions and possibilities and to connect with them.

In addition, talking with the person about their experience will allow them to structure their thoughts, reflect on their own situation and maintain or gain power over their situation.

There are many possible interventions around loneliness and these moments of discussion will help identify the appropriate action, whether it be through direct action or by guiding them to an appropriate agency (Schoenmakers, 2020).

As explained above, it is essential to start with the person. The following are the different factors involved in a person-centered approach (Freedman and Nicolle, 2020):

- **Exploration:** What is the person experiencing now? Discuss with the person their current experience and examine their level of loneliness
- **Explore solutions and goals:** What are possible and appropriate solutions? Work with the person on their future: How do they see it? What would they like to change? What are her strengths, her interests? How can they bring about change?)
    - Be careful to differentiate between the objectives set by the person and those of the professionals
    - This point is important in all situations and interventions!
- **Action:** Based on these objectives: what needs to be done now to implement them?
- **Reduce barriers to implementing interventions:** transportation, mobility restrictions, income...

6. Prevention of loneliness

In addition to providing help and support to people who experience loneliness, it is also important to implement preventive actions. When we work within this framework, we only target relational loneliness for which an external action can have significant preventive effects. For emotional loneliness, prevention relies less on actions than on the person's ability to cope with the loss of a loved one or another difficult event.

Before looking at the various prevention options, it is important to remember that it is normal to feel lonely from time to time. Like any emotion, it becomes problematic when the feeling is prolonged over time and brings significant suffering to the person.

Several actions can be considered, both on an individual and community level. Several practices are developed in our "overview of good practices" tool, here are some examples:

- Warm phone line : *Free number that residents of the city can call to ask for a conversation. The volunteers can also identify if that person may need other services* (initated by the community of Bilzen)
- Door to door : *Door to door visits by neighborhood volunteers to (single) senior citizens aged 75 and older.* (initated by Sint-Trudien community in collaboration with SAAMO Limburg)
- Chat bench : *Special "Chat bench" that offers citizens sitting on it to discuss and exchange among themselves. Whoever sits on this bench signals : I feel like listening and wanting to tell stories.* (initiated by the Seniors' Advisory Council in Baden-Württember)
- Neighbourhood Bar : *Mobile and affordable coffee bar that takes place in targeted neighbourhoods during the summer period* (initiated by Oasis Belgium vzw)

7. Network

The lists below are intended to give you an idea of some of the organizations working on loneliness and are not intended to be exhaustive. If you are looking for such organizations or groups, we suggest that you contact the municipality of your patient/beneficiary in order to find out what is set up and exists in and around their locality.

NETHERLANDS:

- **The municipalities in South Limburg** are all more or less active in preventing loneliness. Among others, good examples are the municipalities of Heerlen and Stein.
- **KBO-Limburg:** KBO Limburg stands up for the interests of all seniors. The KBO has branches in almost all towns and villages and has a strong position in the province and municipalities. KBO Limburg stands for meeting and looking out for each other. Every year, the local KBO departments provide a wide range of activities. There are many walks and bicycle rides, there are regular outings, walk-in moments around tablets and computers, thematic meetings on numerous topics and much more. Each department has a different programme.
- **De Zonnebloem:** National Association de Zonnebloem enriches the lives of people with physical disabilities and those of its volunteers by enabling social and recreational activities. The Zonnebloem operates in many regions with local branches.
- **Humanitas:** The Humanitas association is a national voluntary organisation. The volunteers help people change their situation on their own. Humanitas works in many regions including Maastricht-Heuvelland. Humanitas has special programmes against loneliness.

GERMANY:

- **Kompetenznetz Einsamkeit:** a project that runs until 2025 and aspires in gathering all existing

information about loneliness and implement it in political and social practices. The main goal is to enhance solidarity and social harmony by bringing together in a "network" various stakeholders (services providing help and advice, projects against loneliness, projects aiming to connect, etc), and encourage them in exchanging information with the aim to actively prevent and combat loneliness. Numerous organizations and services participate in this project, such as:

- **Silbernetz eV**, that contains three sections: 1. **Silbertelefon** where people over 60 can call anonymously, 2. **Silbernetz friendship** where seniors can have a more personal contact through telephone with volunteers once a week and, 3. **Silberinfo** where people can ask information about services for elderly care.
- **Freunde alter Menschen e.V.:** an organization that works with volunteers and employees all over the world to combat loneliness of seniors with a focus on older people with mobility problems.
- **Radeln ohne alter Deutschland:** an association based in Bonn but also available in 80 different cities of Germany. It offers older people and people with mobility problems rickshaw rides from volunteers. Their motto is "Everyone has the right to have the wind in their hair".
- **Miteinander-Füreinander: Kontakt und Gemeinschaft im Alter:** a project that runs from 2020 till the end of 2024 in 112 different locations in Germany. The goal is to get in contact with more and more old people who are at risk in experiencing loneliness. They offer support, care services and volunteer opportunities.

GERMAN-SPEAKING BELGIUM:

- **Josephine-Koch-Service V.o.G:** created by the board of directors of the Saint-Nicolas hospital in Eupen, JKS offers, through its volunteers, various activities (transport, afternoon meetings, home visits...) for the patients of the hospital but also for the older people of the city of Eupen.
- **Dienststelle für selbstbestimmtes leben:** service that aims in accompanying every person that is in need of an adjusted support. They especially propose help to support social interactions (assistance with mobility, use of computer tools etc.) or even help people in orienting themselves in their health care.
- **Haus der Begenung:** a place to meet people, do activities, raise awareness and train people who are looking for help or who feel isolated.

DUTCH-SPEAKING BELGIUM:

- **The municipalities in Limburg** are all more or less active in preventing loneliness. Several municipalities have a Local Service Centre. This is a meeting place where all kinds of activities

and initiatives are organised for the wider population, with a specific focus on senior citizens.

- **Saamo Limburg:** SAAMO Limburg brings vulnerable people together and works with them to find solutions to the collective problems they experience. Many problems can be tackled by people themselves: making life in the neighbourhood more pleasant, embellishing a square, setting up meetings, exchanging experiences, etc. We stimulate and support them and can call on the services of many volunteers.

- **Samana:** Samana is an association of and for all people with a chronic illness or a need for care, informal carers and volunteers who strengthen each other in a multifaceted personal development and a full participation in society. That is why Samana works on:

  - Warm social contact and building and strengthening social networks
  - Nurturing happiness
  - Well-being and carrying capacity
  - Defending interests in which testimonies and experience expertise of CZM and MZ are central.

  Everyone's voluntary commitment is crucial here. Together you can do more than alone. Samana believes in and build a warm society: an inclusive community, where people care for each other, where presence is an answer to loneliness and where everyone can contribute, including the most vulnerable.

- **Welzijnsschakels:** Strengthening together. Welzijnsschakels believes that every person deserves equal opportunities, basic rights and respect. That is why we work against exclusion due to poverty or origin.

  We do this with local Welzijnsschakels full of volunteers who, together with families experiencing exclusion, work towards a better society.

  Meeting is a key word in the fight against exclusion. Welzijnsschakels want to offer opportunities to everyone who experiences exclusion due to poverty or origin, and we do that while meeting each other, in our own neighbourhood.

FRENCH-SPEAKING BELGIUM

General associations for loneliness

- **"Hear Me"** phone application: it is aimed at individuals who need to speak and express themselves and do not feel they have someone to listen to them. This application is for all generations and is not specifically designed for the elderly.
- **Babbelkot ASBL:** Association located in Brussels. It allows people to meet each other, to take a

step to break their loneliness by making new acquaintances and new links. It also has a mission of reintegration.

- **Senrj:** Association that takes into account the impact of loneliness and social isolation on the psychological and physical balance. Accompaniment of the beneficiaries towards an active and quality life through the creation of individual and collective projects. Also inter or intra generational projects. Throughout French-speaking Belgium.

Specific associations for loneliness among the older / caregivers

- **ASBL entr'âges:** association which wants to be facilitator of the intergenerational link. They can bring a methodological help. Located in Anderlecht.
- **Ecoute Seniors:** Service of Infor-Homes Brussels. Ecoute Seniors offers personalized listening and support. Ecoute Seniors can consider ways of improving well-being and, if necessary, find a professional who can help the person in need.
- **Respect Senior:** Walloon Agency for the fight against elder abuse. Respect Seniors has branches throughout Wallonia.
- **Bras dessus bras dessous:** Intergenerational and intercultural meetings. This association brings together people over 60 years old living at home and expressing a feeling of loneliness and/or social isolation with younger neighbors wishing to spend some time. Bras dessus Bras dessous is present in the municipalities of Forest, Uccle, Anderlecht, Nivelles, Ottignies Louvain-La-Neuve, Walhain and Rixensart.
- **The Hestia Red Cross Service:** aims at fighting against the social exclusion of vulnerable people (elderly people, disabled people...) but also at relieving the close caregivers. The goal is to improve the social and relational well-being of people isolated by age and illness.

- **ASBL Aidants proches:** It offers information and references according to the needs, wishes and resources of the caregiver (local services/organizations, respite resources, personal assistance and care resources, law and legislation, etc.). Also, if the caregiver wishes, she offers support in the steps to take.

  - **"Info'Aidants" hotline:** 081/30.30.32. A free, personalized and confidential telephone helpline for informal caregivers.
- **The "SAM" network:** A Web platform for close caregivers. A telephone hotline for caregivers who feel they are in difficulty.

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TOPIC 3:

A reflection on their practice, their role and their boundaries

Learning goals:

1. To be able to reflect on the work of the respective professional, the vision we have and our feelings

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Define role and limits and how to pass them on to the beneficiaries

THEORY

No theory because it depends on the context.

PEDAGOGY

Start thinking about these themes:

- Boundaries specific to each profession. One definition could be : the limits to the relationship between someone in a professional role and the person in their care, the borders that mark the edges between a professional relationship and a personal relationship. They are like the riverbanks to the river, allowing work to take place, in a defined space. (https://professionalboundaries.org.uk/faq/)
- To understand the possible limits in relation to the older person
- To know one's own limits

As a professional or volunteer, it is important to be able to question one's practice as much on the well-being of the beneficiary as on that of the (non)professional. For this, several elements can be addressed and worked at once or on a regular basis:

- The objectives set by the worker (volunteer or professional) or their organization
- Their vision of the helping relationship
- Reflection on their needs to feel safe in their work
- Reflection on how to establish a relationship of trust without feeling illegitimate to set the framework
- Reflection on how to combine the pathology/health condition (mental/physical) of the client with their own limits/with the framework of the institution
- Reflection on the framework of their function and its limits (the obstacles that this can bring

but also how the limits participate in the helping relationship)
- Reflection on concrete situations: situations where they have been able to set their limits, situations where they have been exceeded and did this meet a need
- The relationship with the professional worker or with the volunteer
- ...

Before addressing these different elements, make sure you agree on what you mean by the themes addressed. For example, take the time to define what you mean by "feeling safe", "the relationship of trust" etc.

It can be interesting to address these points with them once during the training to allow them to reflect or deepen their reflection on their practice and to come back to them regularly to allow them to adjust or validate their reflection.

These different themes can be addressed in several ways:

- Reflection in pairs : for example, in your opinion, what are the limits of your role? Have you ever been confronted with a situation where you had to redefine your professional boundaries? What is your vision of the helping relationship? Have you ever had the impression that you were not legitimate in your support? What kind of collaboration do you imagine between the volunteers and the professionals?

- Round table reflection

    - Based on real-life situations. For example: start by going around the table, have each person reflect and tell the others about a moment, a situation where he/she felt powerless or where he/she did not feel comfortable, he/she had the impression that the request went beyond his/her role...
    - Then reflect together, on the basis of experience or the person's story, on the answers to give to this situation
    - Based on reading
    - Based on the content of the training
    - Based on cards such as Dixit

Trainers' guide

Here you will find ideas and tips to make the theoretical content more dynamic and to involve your participants in the training. Some of the recommendations can be applied to any theoretical content of the training, while others will be more specific to certain topics.

Based on the principle that people can be more or less receptive to one or more learning methods, we suggest pedagogical tracks that call upon different forms of skills.

In order to make the best choice of the suggested teaching tools and resources, it is essential to ask yourself several questions: the training modalities (face-to-face, distance, hybrid...), the time you have, the predefined objectives and the audience.

Finally, before starting the training, it is essential to ask yourself about your posture as a facilitator. We all have personal representations of the world and what makes it up. The same is true for loneliness and the elderly. These representations will influence our behaviour. It is essential that, as a facilitator, you are aware that these representations may differ from those of the participants. You must therefore remain neutral, adopt a position of listening, non-judgment and non-blaming while relying on accurate and verified information.

HOW TO USE THIS TRAINING?

This training consists of three parts:

1. A part of theoretical content to approach "What is loneliness".
2. A more practical part to work on the feeling of loneliness with the beneficiary/patient.
3. A more reflective part on one's own practice.

This training has been created to suit both a professional and a volunteer group with the intention that the trainer can use it independently. Each audience is different and the proposed format allows you to select the content and approaches that will be the most adapted to your objectives. Thus, you can combine a theoretical part with two practical parts by using video testimonials or a role play. You can also approach only one part, this training is yours.

Topic 1

START

Before the beginning of the training: It may be interesting to ask the participants, before the first day of the training, to already think about what loneliness is for them, and to think of a situation they may have encountered in their life or during their clinical practice.

Day of training: Possibly, communicate the advertisement: https://www.youtube.com/watch?v=SsAMEWeeTxg. The last sentence " Profitez de vos proches, ils ont encore beaucoup à vous transmettre " means:

- "Enjoy your loved ones, they still have a lot to pass on to you" in English
- "Genießen Sie Ihre Lieben, sie haben Ihnen noch viel zu vermitteln" in German
- Geniet van je geliefden, ze hebben nog veel aan je door te geven" in Dutch

Also take a moment to set the framework with the participants (respect for others, listening, caring, respect for schedules etc.). After this moment of discussion, take some time for participants to know each other, to establish a dynamic by using "ice-breakers".

Icebreakers:

- Ex 1: *in motion*

  The room is divided in 2 and each half of the room represents an answer to the following questions (e.g. "what do you prefer, tea or coffee?", "the beach or the mountains?", "summer or winter?", "Spain or Italy?"... "who feels more lonely, the young or the old?") or/and the same idea with a central point and increasingly distant areas (e.g. "do you live far or near Liège?" .... "I myself know loneliness in my life: not at all, a little, sometimes, often...). The trainer can also answer the different questions so that everyone can become aware that loneliness can affect everyone.

- Ex. 2: *A truth and a lie*

  This exercise is done in pairs. One person says two statements (e.g. "I have 4 children" and "I skydived"), and the other has to guess which statement is a lie and which is true.

- Ex. 3: *with illustration*

  With the help of images (e.g., a card like the board game "dixit"), the participants explain their current mood and state of mind.

- Ex. 4: *Human bingo*

  The trainers write several statements (concerning lifestyle, projects, habits, etc.) in a table and ask the participants to find people in the room who correspond to these sentences and to cross them out on the sheet of paper once they have found them. The bingo is successful when all the boxes in a line (vertical, horizontal, diagonal) are checked off. E.g.: I like to watch Christmas movies, I listen to rap music, I love to hike...

- Ex. 5: *Generation serpentine*(for participants of various ages)

  Participants are asked to form a circle according to their age: the youngest is on one side - the oldest on the other. Each person in turn says his/her age and name. The facilitator develops with this "generation snake" the possible delimitations of generations. Who belongs to which generation? The facilitator points out the possible boundaries: for example, young students are distinguished from students aged 22 to 27, apprentices and young workers, or the different generations in the group of people aged 55 and over. By asking brief questions or making their own observations, the facilitator can make it clear that the event brought together more than two generations (young and old).

REPRESENTATION AND STEREOTYPES ABOUT OLDER PEOPLE

This game can be started with a preference game around what is old and young by asking the group what they prefer (moving to one side of the room or the other depending on the answer chosen):

- A Blu-ray or vinyl
- An old house or a modern house
- Young wine or old wine
- Fresh fruit or dried fruit
- Young cheese or old cheese
- Dumbledore or Harry Potter
- ...

Then ask the group what they thought of the game? Is what is old always not as good as what is young? And you can finish with two pictures of an old woman/man or a young woman/man, ask the group what is different from the other questions? Conclude by bringing up the theoretical part of stereotypes.

Alternative: ask participants for the first three words that come to mind when they think of an older person (or write them down and analyse them all together).

Alternative: In addition, in order to make participants aware of their own stereotypes, the following questions can be asked and compared to the actual numbers

- What percentage of people aged over 65 in Belgium do you think are (1) living in an institution (MR/MRS), (2) suffering from depression, (3) feeling lonely, and (4) have hearing problems?
- *Actual figures:* 8% institution, 11% depression, 9% lonely (19% just after COVID), 33% hearing.

WHAT IS LONELINESS?

Introduction to the subject of loneliness: using the advertisement (URL link), Dixit card (talk about representations of loneliness with the help of images)

Testimonies (to be provided): from the viewing of testimonies, ask participants to find elements that help to detect that the person is suffering from loneliness, or initiate a role play on how to discuss loneliness, what ideas to counter loneliness, what consequences and what are the potential risk factors identified in the testimony, etc.

Alternative - Brainstorming: what is loneliness, what are the consequences, how to counter loneliness, what is an elderly person... brainstorming in groups or small groups, orally or in writing.

These ideas can also be adapted to the sub-section "How do you identify a person who is experiencing loneliness?"

CORRELATES OF LONELINESS

Create 3/4 teams (depending on the number of participants) and give them a list of possible risk factors, including some that are wrong (e.g., hair colour) and some that may be off (e.g., being a motorsports enthusiast). Teams take turns naming one item from the list that they think is a risk factor. The game is then debriefed and the list is explained, in connection with the associated theoretical part.

HOW TO IDENTIFY A PERSON WHO FEELS LONELY?

One idea might be to have each participant fill out one of the questionnaires individually and explain to them what the person's score means (based on the threshold). A discussion can be initiated on what the threshold score means, on the importance of taking into account the context in which the person is.

INFLUENCE OF COVID

Before or after the theoretical content on the impact of Covid: Have the group reflect on the current risk factors: e.g., the price of energy, which encourages people to stay at home and is a source of anxiety; the climate situation; the geopolitical situation, etc.

SPECIAL CASES

Also here, suggest a time of reflection on the life events, the stages that can foster a feeling of loneliness (e.g., a bereavement, the loss of a job, children leaving the family nest, retirement, hearing loss, illness, etc.). Then bring in the theory.

Topic 2

COMMUNICATION

To stimulate reflection on the influence of our own feelings as professionals and the impact this can have on care/guidance. E.g., if I am lonely and I meet a person who is lonely, will I act with them as I would like them to act with me? Or will I be able to step back enough and act in empathy?

The different parts (how to communicate, prevention, identifying needs...) can be developed/worked on in the form of role plays.

For each part, it is also possible to do an oral or written brainstorming.

TESTIMONY

Throughout your training, whether as an introduction, illustration or reflection, you will be able to rely on the testimony of Anne who agreed to speak to us on camera. Anne is 73 years old, suffers from polyneuropathy and experiences loneliness. Two videos are available, a short version (8'53'') and a long version (23'19''):

Short version:

- Presentation
- What is loneliness for you?
- A typical day?
- What is the most painful thing for you?
- Is it possible to suffer from loneliness even when surrounded by people?
- A solution to loneliness?

Long version:

- Presentation
- What is loneliness for you?
- A typical day?
- What is the most painful thing for you?
- Is it possible to suffer from loneliness even when surrounded by people?
- What do you need?
- What do you think of nursing homes?
- What do you think of home care services?
- Do you think there is a lack of consideration?
- A solution to loneliness?
- A meeting?
- What do you think about intergenerational contact?

Here are some suggestions for an optimal use:

- "What is loneliness for you" and "Can one suffer from loneliness even when surrounded": These two parts can accompany a reflection on the definition of loneliness.
- "A typical day": this part can accompany a reflection exercise "how do you imagine a typical day of a person who feels lonely at home? What might it be like?"
- "What is most painful thing for you?": this section can accompany a reflection exercise "if you were suffering from loneliness, what would be most distressing thing for you?"
- "What do you need": this part can accompany a reflection exercise based on the "typical day" part and "what is the most painful": imagine the person's needs based on these two parts.
- "Social networks", "what do you think of nursing homes", "what do you think of home services", "a solution to loneliness", "a meeting" and "what do you think of intergenerational contacts": these parts can be used as a basis to think about interventions and support.
- "Do you think that there is a lack of consideration": this part can be used to reflect upon representations and stereotypes.

SETTING IN SITUATION

Here are several vignettes of people who may or may not be lonely. They can be used as a basis for a reflection to define loneliness or the needs of the person or for a role play.

If you set up a role-play, you can then go into a reflection phase. For example, you can ask participants how they felt during the role-play. You can also ask them to note something about the other person that they found particularly interesting.

Michel is married to Claudine, they both live in their house in a small village. They have three

children who have moved to the city. With their work and their own family, they can only visit their parents once a month for a family meal. Because of their age, Michel and Claudine no longer drive and are therefore dependent on public transportation, which is scarce in their village. They spend a lot of time together playing board games, chatting and cooking. When asked if they feel lonely, they answer that yes, despite the presence of the other, they both suffer from loneliness.

Gerard has been a widower for 5 years now. He lives in an apartment in town with his two cats. By choice, they have no children but have several nieces and nephews. He does not have many visitors at home but is regularly taken to family dinners. He also volunteers with a clothing drive organization. As a group, they sort, store and sell the clothes they receive. With his various activities, he spends a lot of time outside with other people. When asked about his feelings of loneliness, he says he suffers from feeling alone most of the time.

Danielle is 76 years old and lives in the city, without a husband or children. She spends a lot of time reading, writing and sewing. She also likes to go to the cinema, which is right next door to her house. She has always been nourished by culture. She has a few friends whom she sees from time to time but spends most of her time alone. When asked about her feelings of loneliness, she says she does not suffer from them.

Claire is 80 years old and lives alone in her house in the country. Because of sight problems, she can no longer drive and is therefore dependent on others and on public transport. She was married to Patrick who died a year ago. She is often lonely but doesn't know how to spend time with other people, not just meet them for a few minutes. She sometimes has difficulty getting around and feels that this limits her interactions and opportunities to reach out.

Profil:

Albert

- 82 years old
- Widower
- Feels physically fit
- Has a daughter who calls him often but lives in Canada
- Very modest, does not mean he is lonely, but he misses a person with him every day

Géraldine

- 66 years old
- Married

- No children
- Says she feels lonely but does not want to do activities outside her home. Organizations have already come to her home but have not been able to put anything in place.

Lonely? Let's unite!

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