# A qualitative study of barriers to social participation among lonely older adults: the influence of social fears and identity

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D. Clin. Psy. Thesis (Volume 1)

2014

University College London

## UCL Doctorate in Clinical Psychology

## Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

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Date: September 2014

## Overview

Loneliness among older adults is a significant predictor of morbidity and mortality, and is therefore increasingly recognized as a major public health problem. Whilst mechanisms underpinning the development of loneliness in later life are poorly described, it has been associated with reduced levels of social participation outside the home. This thesis therefore sought to explore barriers to social participation among older adults.

**Part 1** comprises a systematic review of older adults' subjective experiences of barriers to social participation. Fifteen qualitative studies were identified and assessed using Thematic Analysis (Braun & Clarke, 2006). Whilst results aligned with previous findings, they also emphasized several novel barriers that may guide future research, including: local population turnover, perceived neighbourhood danger, ageism, economics and power, social skill and confidence problems, identity processes, and adaptation to age-related changes.

**Part 2** comprises an empirical study of barriers to social participation in a sample of lonely older adults living independently in London, England. Here, particular attention was paid to processes of identity, which may hold particular influence over social participation. An inductive qualitative approach, based on semi-structured interviews and Thematic Analysis (Braun & Clarke, 2006), was employed. Findings highlighted that lonely older people commonly minimise the difficulties they face alone and avoid social opportunities, due to significant fears about the possibilities of social rejection and/or losing valued aspects of their identities.

**Part 3** comprises a discussion of issues pertinent to the conduction of research in this field. Topics explored include: the effects of personal assumptions upon qualitative findings, the management of emotional responses to interviews with very lonely older people, ideas for future research, and the impact of the present work on practice.

# Table of Contents

**Part 1: Literature Review**

**Part 2: Empirical Paper**

## Table of Figures

## Table of Tables

## Abbreviations

| | |
|---|---|
| JS | Dr Joshua Stott (Research Supervisor) |
| GC | Dr Georgina Charlesworth (Research Supervisor) |
| KS | Dr Katrina Scior (Research Supervisor) |

## Acknowledgments

I would like to acknowledge the generous contributions of the study participants, without whom this work could not have been conducted. They welcomed me into their homes, thoughtfully answered my questions, and offered me detailed and often very personal insights into their lives. I consider myself truly fortunate to have met and worked with such kind and interesting people, who furthermore, brought such richness to this work.

I am also extremely grateful to all the organisations that agreed to collaborate on this project; without their faith in my plans, and me, this work would not exist. I am particularly thankful to Robert Edmonds (CEO, Age UK Haringey) for being so receptive to my ideas when I first approached him, and for helping me to develop a project that held relevance to current practice. Perhaps most importantly however, he took a chance to give me the organisational backing that I needed to get the project off the ground, and for that I will remain truly indebted. I am also extremely grateful to all other personnel who assisted me, either by welcoming me into their organisations and allowing me to collaborate with their teams, or by facilitating the practical process of recruitment. I am especially grateful to the following individuals: Ashraf Choudhury, Sarah Green-Fried, Kathy Wiltshire, Nessar Ahmed, Paul Goulden, Jennifer Czaja, Sheena Dunbar, Christine Bateson, Chris Smith, Herve Nourisson, Amy Shearer, Andy Murphy, Lisa Lucas.

Next I would like to sincerely thank all three of my research supervisors for their unwavering guidance and support throughout this project. I am particularly grateful to Dr Josh Stott for backing me in the pursuit of my own research ideas, despite the considerable uncertainties that they entailed, particularly at the outset of the project. I am thankful not only for his consistently helpful practical and theoretical guidance throughout, but also for the stabilising support he offered, especially during those (not infrequent) moments when I felt distinctly overwhelmed and wobbly. I am very grateful to Dr Katrina Scior for her expert guidance on all methodological aspects of the study, and additionally her assiduous, thoughtful and incisive comments on my work throughout. Finally, I am particularly thankful to Dr Georgina Charlesworth for generously sharing her considerable expertise in late life loneliness, which helped me to significantly refine and improve my work in many ways.

I am also very thankful to Bryony Insua-Summerhays, who enthusiastically assisted me in the arduous task of interview transcription.

Last but certainly not least, I would like to acknowledge the love and support of my friends and family, without whom I definitely wouldn’t have made it this far: Andrew, David, Lia, Jenny, Darshan, Becky, Mum, Dad, and Grandma.

# Part 1: Literature Review

## Subjective barriers to social participation among older adults: a systematic review

## Abstract

***Introduction.*** *Reduced social participation among older adults is associated with significantly increased levels of morbidity and mortality, and is therefore considered a major public health problem. However, the mechanisms underlying reduced social participation in later life are poorly understood. Given this lack of knowledge, the examination of older adults' subjective experiences of reduced social participation may lead to the development of theories that can be tested in future research.* ***Methods.*** *The current systematic review sought to examine studies of older adults' subjective experiences of barriers to social participation. A systematic search process retrieved fifteen relevant studies, all of which utilized qualitative techniques. Thematic Analysis (Braun & Clarke, 2006) was employed to analyze data.* ***Results.*** *Seventeen themes were generated and grouped into four over-arching categories of barriers to social participation: Biophysical, Social, Material and Psychological.* ***Discussion.*** *Results aligned with and expanded upon previous research. However, findings also highlighted several barriers to late life social participation that have not been the focus of previous work and may guide future research, including: local population turnover, perceived neighbourhood danger, ageism, economics and power, social skill and confidence problems, identity processes, and adaptation to age-related changes.*

## Introduction

Although definitions of social participation vary (Levasseur, Richard, Gauvin, & Raymond, 2010), it is commonly regarded as an individual's involvement in interpersonal interactions outside of the home (Levasseur et al., 2011; Maier & Klumb, 2005). Such activities may take many forms including leisure pursuits with others, social group participation, neighbourhood activism, and paid or voluntary work.

Older adult populations typically show significantly lower levels of social participation than other age groups (Bowling & Stafford, 2007; Bukov, Maas, & Lampert, 2002; Desrosiers et al., 2009; Desrosiers, Noreau, & Rochette, 2004; Pollack & von dem Knesebeck, 2004). Multiple theories have been offered to account for this phenomenon. The *Disengagement Theory of Ageing* (Cumming, Dean, Newell & McCaffrey, 1960; Cumming & Henry, 1961) suggested that withdrawal from society in later life was both normative and unproblematic; however, such ideas are now largely discredited (see Achenbaum & Bengtson, 1994). The more recent *Socioemotional Selectivity Theory* suggests that older people make greater investments in fewer relationships of higher quality because they are motivated to pursue emotional wellbeing rather than novel experiences (Carstensen, Fung & Charles, 2003). Whilst altered social preferences may therefore account for moderate reductions in social participation with increasing age, compelling evidence suggests that significant reductions should be considered problematic because they are associated with a range of negative health outcomes. For example, reduced social participation among older people has been associated with: increased disability, depression, loneliness, cognitive impairment, and increased mortality (Bassuk, 1999; Beland, Zunzunegui, Alvarado, Otero, & del Ser, 2005; Bennett, 2002; de Leon, 2003; Fabrigoule et al., 1995; Glass, de Leon, Marottoli, & Berkman, 1999; Glass, de Leon, Bassuk, & Berkman, 2006; Glei et al., 2005; Hsu, 2007; Lennartsson & Silverstein, 2001; Maier & Klumb, 2005; Menec, 2003; Nakanishi & Tatara, 2000; Pollack & von dem Knesebeck, 2004; Walter-Ginzburg, Blumstein, Chetrit, & Modan, 2002; Wang, 2002). In response to this evidence, the enhancement of social participation among older adults is a key target of national and worldwide policy (Age UK, 2013; Department for Work and Pensions, 2013; World Health Organisation, 2002).

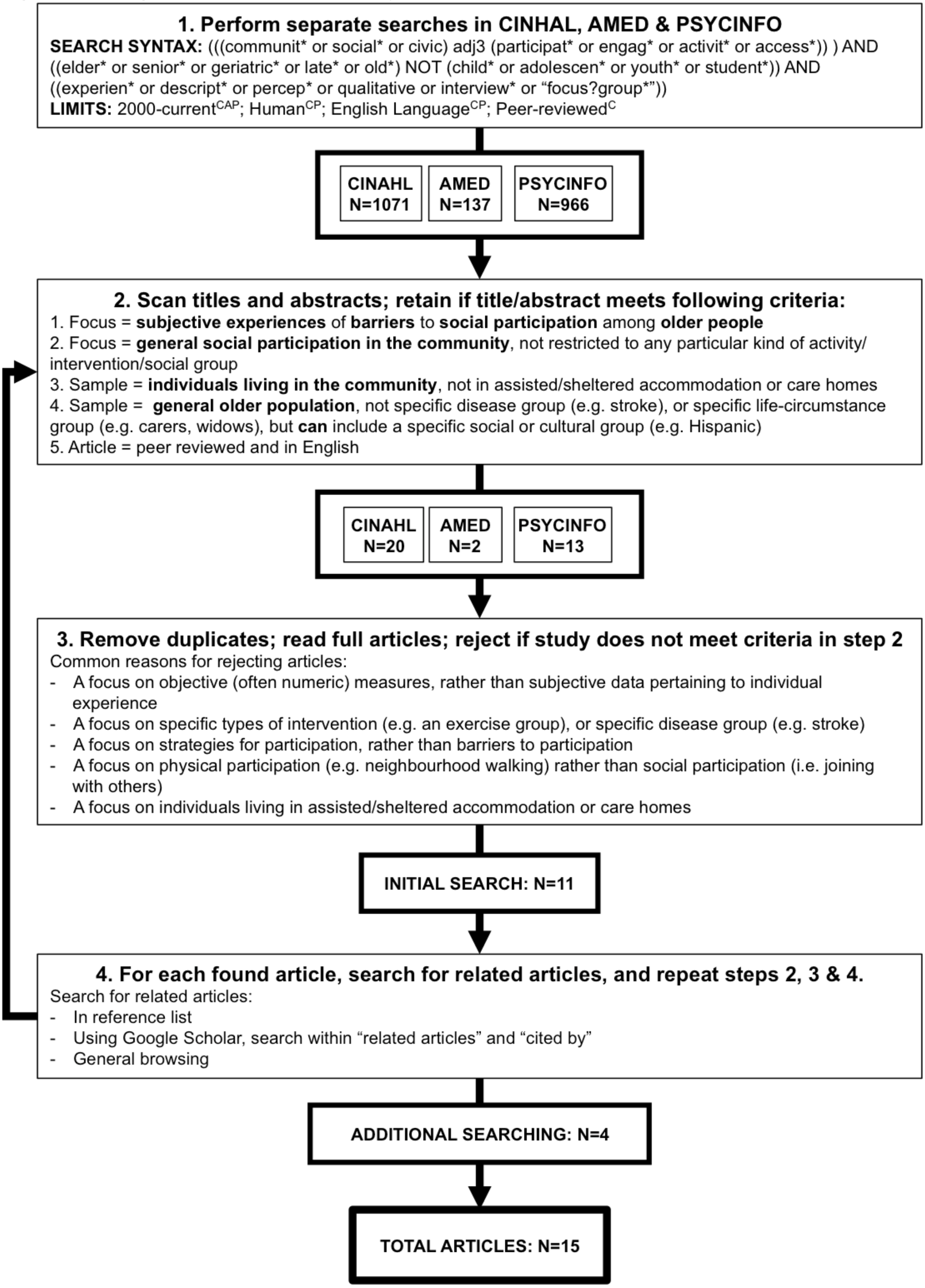
The etiology of reduced social participation in later life is so far poorly described, possibly because contributory factors are complex and multi-factorial. Nevertheless, research has delineated a range of risk factors, including: higher age, illness/disability, lower socioeconomic status, lower educational/occupational attainment, ethnic minority status, lower subjective ratings of neighbourhood factors (e.g. resources/accessibility/pleasantness), and reduced social contacts (Adamson, Lawlor, & Ebrahim, 2004; Barnes, de Leon, Bienias, & Evans, 2004; Bowling & Stafford, 2007; Bukov et al., 2002; Lefrancois, Leclerc, & Poulin, 1997; Levasseur et al., 2011; Pollack & von dem Knesebeck, 2004; Richard, Gauvin, Gosselin, & Laforest, 2009; Wilkie, Peat, Thomas, & Croft, 2007). To take all of these factors into account, Bukov et al. (2002) suggest that reduced social participation may result from a general reduction in resources across multiple domains of life, including physical, psychological, social and economic. Nevertheless, there is much disagreement about the operation of individual risk factors; for example it is unclear whether poor health leads to reduced social participation, whether reduced social participation leads to poor health, or whether both of these processes operate reciprocally. Since most studies to date have focused on the measurement of researcher-defined factors, novel and more ecologically valid insights might be gained by attending to the perceptions and subjective experiences of older adults. Indeed, a small literature of this kind exists; however, it is dispersed across different disciplines and rarely integrated into discussions of social participation. Thus, the current study comprised a literature review of studies that have investigated older adults' *subjective* experiences of *barriers* to social participation. By integrating the available evidence pertaining to older adults' own perspectives, this review aimed to develop current understandings of factors that contribute to reduced social participation in later life, and to develop hypotheses that might be empirically tested in future research.

## Methods

### Search strategy

Preliminary work revealed that literature regarding social participation in later life is widely dispersed. Thus, literature searching was performed within three distinct research databases covering a range of academic disciplines: PSYCINFO (covering psychology, behavioural sciences and mental health), AMED (covering physiotherapy, occupational therapy, rehabilitation, and speech and language therapy), and CINAHL (covering nursing and allied health professions). In each of these databases, a search was performed to retrieve articles, published since the year 2000, that simultaneously examined: (1) social participation, (2) older adults, and (3) subjective experience. In order to retrieve as many relevant articles as possible, synonyms for each of these factors were employed in the search syntax (see Figure 1.1). Care home residents were excluded because it was felt that factors influencing social participation would vary between those living in close proximity to peers, and those living independently.  Inclusion criteria did not specify any particular methodological approach; however, the requirement for a focus upon subjective experience meant that identified studies were more likely to be qualitative than quantitative. Retrieved articles were subsequently examined to determine whether they also focused on *barriers* to social participation (this criterion was not included in the search syntax to maximise inclusivity of search results). This searching process, which is described in detail in Figure 1.1, retrieved 15 articles that met criteria for inclusion in the current review.

**Figure 1.1 Diagram to illustrate search process**



**1. Perform separate searches in CINHAL, AMED & PSYCINFO**

**SEARCH SYNTAX:** (((communit* or social* or civic) adj3 (participat* or engag* or activit* or access*)) ) AND ((elder* or senior* or geriatric* or late* or old*) NOT (child* or adolescen* or youth* or student*)) AND ((experien* or descript* or percep* or qualitative or interview* or “focus?group*”))

**LIMITS:** 2000-current$^{CAP}$; Human$^{CP}$; English Language$^{CP}$; Peer-reviewed$^{C}$

**2. Scan titles and abstracts; retain if title/abstract meets following criteria:**

1. Focus = **subjective experiences** of **barriers** to **social participation** among **older people**
2. Focus = **general social participation in the community**, not restricted to any particular kind of activity/ intervention/social group
3. Sample = **individuals living in the community**, not in assisted/sheltered accommodation or care homes
4. Sample = **general older population**, not specific disease group (e.g. stroke), or specific life-circumstance group (e.g. carers, widows), but **can** include a specific social or cultural group (e.g. Hispanic)
5. Article = peer reviewed and in English

**3. Remove duplicates; read full articles; reject if study does not meet criteria in step 2**

Common reasons for rejecting articles:

- A focus on objective (often numeric) measures, rather than subjective data pertaining to individual experience
- A focus on specific types of intervention (e.g. an exercise group), or specific disease group (e.g. stroke)
- A focus on strategies for participation, rather than barriers to participation
- A focus on physical participation (e.g. neighbourhood walking) rather than social participation (i.e. joining with others)
- A focus on individuals living in assisted/sheltered accommodation or care homes

**4. For each found article, search for related articles, and repeat steps 2, 3 & 4.**

Search for related articles:

- In reference list
- Using Google Scholar, search within “related articles” and “cited by”
- General browsing

***KEY:*** *$^{A}$, limit used in AMED; $^{C}$, limit used in CINAHL; $^{P}$, limit used in PSYCINFO; adj3, search syntax which returns articles only if two searched-for terms are found within 3 words of each other; N, number of articles.*

## Critical appraisal of articles

Most researchers agree that systematic reviews of qualitative literature should take into account the quality of studies included. However, methods for critically appraising qualitative studies are subject to considerable debate, and there are no universally agreed procedures. Indeed, there is a proliferation of checklists and protocols in the literature (Cohen & Crabtree, 2008; Walsh & Downe, 2006; www.qualres.org), which means that researchers must determine the best procedure for their particular needs.

A sizeable literature outlines the difficulties inherent in determining a unified approach to the critical appraisal of qualitative studies (Barbour & Barbour, 2003; Barbour, 2001; Cohen & Crabtree, 2008; Dixon-Woods, 2006; Dixon-Woods, 2004; Dixon-Woods et al., 2007; Long & Godfrey, 2004; Malpass et al., 2009; Walsh & Downe, 2006). A central problem is that "qualitative research" is not a unified entity, and instead reflects a plurality of approaches, encompassing a wide range of epistemological stances. For example, qualitative research may be based upon realist principles (e.g. Interpretive Phenomenological Analysis; IPA; Smith & Osborn, 2003), which claim that there exists a single reality that is at least partially knowable. Alternatively, qualitative research may adopt an interpretive perspective (e.g. Grounded Theory; Charmaz, 2006), which assumes that realities are multiple and co-constructed. To some extent, these different approaches entail different indicators of quality: rich descriptions and reflexivity for interpretative studies, and validity-checking procedures for realist studies. Thus, tools for the critical appraisal of qualitative studies need to reflect these differences. Additionally, assessing the quality of interpretations of data (whether within an explicitly interpretive study or not) is fundamentally problematic due to the inherently creative, idiosyncratic and intangible nature of interpretive procedures (Dixon-Woods, 2004). Thus, the critical appraisal of interpretive processes (in comparison to the appraisal of more tangible procedures like sampling and data collection) may necessitate a greater reliance upon subjective judgements (Dixon-Woods et al., 2007).

In the absence of any clear guidelines or evidence-base for choosing an appraisal method, the current author elected to utilize the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP-QRC; http://www.casp-uk.net), because it is well established in the literature (e.g. Campbell et al., 2003; Dixon-Woods et al., 2007). However, in order that this tool could be meaningfully employed with studies occupying various epistemological positions, and in order to appraise interpretation procedures, it was decided that it would be used flexibly in an amended format (see Table 1.1). Thus, although it is intended as a *checklist* of criteria to be satisfied, the author chose to use it as a set of *guidelines* that draw attention to features that may or may not be relevant to quality, dependent on the study type (Barbour, 2001; Dixon-Woods, 2004). Additionally, the author felt that the essentially binary response options within the CASP-QRC were insufficiently detailed to reflect differences between studies and therefore added an intermediate option. Finally, it was decided that a subjective judgement process would be used to supplement the CASP-QRC in order to augment the quality-checking procedure.

**Critical appraisal methodology**

The critical appraisal methodology consisted of 2 phases, both performed by the author: a structured assessment based on an amended version of the CASP-QRC (Table 1.1), and a subjective, holistic judgement. The CASP-QRC was employed as a list of features that may or may not hold relevance to quality, depending on the study type. For each study, the author first considered whether each domain of the CASP-QRC was relevant. For relevant domains, the author then evaluated whether the features of that domain (see Table 1.1) were present in the study. For each domain, possible outcomes were “no features present”, “some features present” or “all features present”, giving a score of 0, 0.5, or 1 respectively, or “not relevant”. For each study, scores were summed and then divided by the number of relevant domains assessed, to give a result in the form of an index ranging from 0 (lowest quality) to 1 (highest quality). This index was then augmented by a subjective and holistic judgement, based on the author’s knowledge of qualitative methodology, in which each study was judged as either “high”, “medium” or “low” quality. Once the author had appraised all studies, another researcher (JS) performed the same steps for two of the included articles, to check the credibility of this approach. Whilst the researchers’ judgements broadly concurred, a few slight differences were noted and minor amendments were agreed upon. All studies were retained for the current review; however, outcomes of the critical appraisal process were taken into account when reviewing findings.

### Analysis

The author employed Thematic Analysis (Braun and Clarke, 2006), to synthesise the contents of the articles included in this review. As far as possible, the author adopted a data-driven approach in order to privilege actual study findings over any pre-established theories. Initially, the author read all articles, in order to familiarise herself with their content. Next, she re-read the articles, and systematically applied codes to all data that bore relevance to the study question; relevance was defined as any finding that explicitly linked a particular experience to reduced social participation, as well as any finding that presented a particular experience within a discussion about reduced social participation. All findings that did not pertain to the study question were ignored. Coding was performed iteratively such that the author checked for the presence of any new codes in all previously coded articles. Following initial coding, a credibility check was performed by another researcher (JS), in line with guidelines for good practice within qualitative research (Elliott, Fischer, & Rennie, 1999). JS read two of the articles, coded them, and then compared results with the author's original codes; whilst both sets of codes were substantially similar, this process led to some minor adjustments. Once coding was complete, the author collated the codes into themes, in discussion with JS. Next, themes were checked against the data and refined in an iterative fashion, by moving back and forth between the themes and the data several times. In this way, unsupported themes were removed, new themes were created, homogenous themes were collapsed, and heterogeneous themes were split. Eventually, the author judged that the generated themes reflected the data as closely as possible, and therefore terminated this iterative refinement process. In a further step, the themes were organised into a smaller number of broader overarching categories.

**Table 1.1 Guidelines for critical appraisal used in the current review, amended from the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP-QRC)**

| | Domain | Features |
|---|---|---|
| **1** | Research aims are clearly stated | •There is a clear statement of the aims of the research. |
| **2** | Qualitative methodology is appropriate | •Qualitative methodology is appropriate.<br>•The research seeks to interpret or illuminate the actions and/or subjective experiences of research participants. |
| **3** | The research design is clear and appropriate | •The researchers have justified the research design.<br>•The researchers have discussed how they decided which methodology to use. |
| **4** | The recruitment strategy is clear and appropriate | •The researchers have explained how the participants were selected.<br>•The researchers have explained why the participants were the most appropriate to address the study aims.<br>•The researchers have discussed any recruitment issues (e.g. why some people chose not to take part, bias in the sample). |
| **5** | Data collection methods are clear and appropriate | •The setting for data collection was justified.<br>•The approach to data collection is clear (e.g. focus group, semi-structured interview, observation etc.)<br>•The approach to data collection is justified.<br>•Data collection methods are detailed and explicit (e.g. how interviews/observations were conducted, whether interview schedules/topic guides were used, etc.).<br>•Methods of recording data are clear (e.g. audio recordings, notes etc.)<br>•Saturation of data has been discussed. |
| **6** | The relationship between researcher and participants has been adequately considered | •The researchers have critically examined their own role, preconceptions, potential biases and influences during various stages of the study, including design, data collection and analysis. |
| **7** | Ethical issues have been taken into consideration | •Methods used to explain research to participants are clearly presented, and are in accordance with appropriate ethical standards.<br>•The researchers have discussed any ethical issues raised by the study (e.g. informed consent, confidentiality, effects of the study on the participants) and how these were managed.<br>•Approval has been sought from an ethics committee. |
| **8** | Data analysis is sufficiently rigorous | •There is an in-depth description of the analysis process, e.g. how categories/themes were derived from the data. |
| **9** | Findings are clearly stated, contextualised and critically assessed | •Findings are explicit.<br>•Sufficient data are presented to support the findings.<br>•The researchers have justified why they have chosen particular pieces of data for presentation.<br>•Contradictory data are presented and taken into account.<br>•The researchers have explored the credibility of findings (for example, through the use of triangulation, respondent validation, external auditing, peer review).<br>•The researchers have discussed the subjectivity of findings (e.g. via detailed contextualisation, consideration of co-creation of findings, analysis of researcher-participant relationship).<br>•Limitations of findings are acknowledged. |
| **10** | Findings are valuable | •Findings are linked back to the study question.<br>•The contribution the study makes to existing knowledge is discussed (including relevant literature, policy, or practice).<br>•The researchers have discussed whether/how findings can be applied to other populations.<br>•The researchers have identified new areas where research is necessary. |

**Table 1.2 Details of articles included in the current review**

| First author | Code | Year | Aim | N | Country | Setting | Wellbeing | Age | Gender | Ethnicity | Data Collection Method | Data Analysis Method | CASP-QRC (range:0-1) | Subjective rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Andonian** | **A** | 2011 | To explore strategies that well older adults employ to maintain social participation, and the aspects of their context that hinder social participation | 7 | US | urban | well | 55+ | M/F | varying | Photovoice | TA-U | 0.95 | high |
| **Buffel** | **B** | 2013 | To explore the experiences of neighbourhood exclusion and inclusion among older people living in deprived urban communities | 226 | England, Belgium | urban, deprived | NS | 60-97 | M/F | varying | SSI | TA-U | 0.55 | medium |
| **Davidson** | **DA** | 2003 | To explore factors affecting older men's participation in different types of social organisations | 85 | England | urban | NS | NS | M | NS | SSI | TA-U | 0.5 | medium |
| **Dwyer** | **DW** | 2011 | To explore how ageing and rurality interacts to produce social exclusion for older rural residents, and how village services might counteract this | 44 | UK | rural | NS | 58-93 | M/F | NS | SSI, FG | Various | 0.7 | medium |
| **Fristedt** | **F** | 2011 | To describe older people's motives for and experiences of mobility and occupational participation outside the home | 42 | Sweden | NS | NS | 75+ | M/F | NS | FG | CA | 0.8 | medium |
| **Gele** | **G** | 2012 | To describe the barriers and facilitators to civic engagement among elderly African immigrants | 24 | Norway | urban | NS | 50-70 | M/F | African (immigrants) | SSI | TA | 0.65 | medium |
| **Howat** | **H** | 2004 | To investigate barriers and facilitators to social participation among older persons | 40 | Australia | urban | varying | 65-94 | M/F | NS | SSI, FG | NS | 0.25 | low |
| **Jansen** | **J** | 2008 | To determine the types of barriers older people perceive as interfering with their ability to participate in restorative activities | 30 | US | urban | NS | 65-92 | M/F | Caucasian | SSI | CA | 0.75 | medium |
| **Martinez** | **M** | 2009 | To identify activities of interest to older people and factors that influence participation | 68 | US | urban | "non-active" | 60-89 | M/F | Caucasian, African American | FG | GT | 0.65 | medium |
| **Rosanova** | **R** | 2012 | To explore factors that constrain choices of social engagement in the context of rural ageing | 89 | Canada | rural | varying | NS | M/F | NS | SSI | TA | 0.65 | high |
| **Sixsmith** | **S** | 2003 | To investigate links between social participation, health and gender among older men living in a deprived community | 18 | England | urban, deprived | NS | 56-84 | M/F | NS | SSI, FG | TA-U | 0.8 | high |
| **Walker, J** | **WJ** | 2013 | To improve understanding of age-related triggers to reduced social participation | 69 | Australia | rural | varying | 65+ | M/F | NS | SSI | TA | 0.75 | high |
| **Walker, R** | **WR** | 2007 | To reveal aspects of neighbourhood which impacts on health, ageing and social inclusion | 20 | Australia | urban | well | 75-93 | F | Australian, British | SSI | GT | 0.8 | high |
| **Yen** | **YE** | 2012 | To identify the types of resources that people use in their neighbourhoods to maintain well-being | 38 | US | mix | well | 62-85 | M/F | White, African American, Latino, Asian | SSI | TA-U | 0.65 | medium |
| **Yuan** | **YU** | 2012 | What forms of social exclusion are faced by Chinese "empty-nest elderly", i.e. seniors in China whose children live elsewhere | 10 | China | urban | varying | 65-87 | M/F | Chinese | SSI | TA-U | 0.75 | high |

***KEY: CA**, Content Analysis, specified type; **CASP-QRC**, Critical Appraisal Skills Programme Qualitative Research Checklist; **F**, female; **FG**, focus group; **GT**, Grounded Theory; **M**, male; **N**, number of participants in study; **NS**, not specified; **SSI**, semi-structured interview; **TA**, Thematic Analysis, specified type; **TA-U**, thematic analysis, unspecified type; **US**, United States; well, participants described as generally healthy and active; **UK**, United Kingdom.*

## Results

Table 1.2 displays basic details of the 15 articles retrieved by the search strategy described above. Populations examined within these studies were wide ranging in terms of size (ranging from N=7 to N=226), nationality (including Europe, China, North America, Australia), ethnicity (including White, African American, Latino, Asian, Chinese), setting (urban, rural), and socio-economic status. Methodologies were also varying, but most studies utilised interviews and/or focus groups, and a variant of Content or Thematic Analysis.

The current analysis generated four overarching categories, and seventeen themes, which are summarized in Table 1.3. This table also identifies the individual studies that provide evidence for each theme, and their relative qualities (studies are ordered by quality from high (right) to low (left), according to the critical appraisal technique describe above). In what follows, study findings are reported, alongside selected quotations from the reviewed articles (the origins of findings and quotations are indicated by study code letters; see Table 1.2). For ease of reading, superfluous segments of quotations have been replaced with an ellipsis (…), and connecting words have been inserted (enclosed in square brackets [ ] ).

### Table 1.3 Overarching themes and their patterns of occurrence in the reviewed studies

| Category | Theme | | A | S | WR | WJ | YU | R | F | J | DW | G | M | YE | B | DA | H |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Biophysical** | Biophysical barriers | | | | ■ | ■ | | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | ■ |
| **Social** | Loss of pre-existing contacts | Loss of partners/friends | | | ■ | ■ | | | ■ | ■ | | | ■ | | ■ | | ■ |
| | | Loss of neighbourhood interactions | | ■ | ■ | ■ | ■ | ■ | | ■ | | | | ■ | ■ | | |
| | | Loss of family contact | | | ■ | | | | | ■ | | | ■ | | | | ■ |
| | Caregiving duties | | | | | ■ | | ■ | | ■ | | | | | | | |
| | Perception of the neighbourhood as dangerous | | | ■ | ■ | | | | ■ | | | | ■ | ■ | ■ | | ■ |
| | Ageism | | ■ | | ■ | | | ■ | ■ | ■ | | | | | | | |
| **Material** | Perceived lack of appropriate neighbourhood resources | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | ■ | |
| | Transportation problems | | ■ | | ■ | ■ | | | ■ | ■ | ■ | | ■ | ■ | | | ■ |
| | Lack of personal financial resources | | | | | ■ | ■ | ■ | | ■ | ■ | | ■ | | | | |
| | Physical layout of neighbourhood | | | | ■ | ■ | | | | | ■ | | | | | | |
| **Psychological** | Lack of social skills and/or confidence | | | ■ | ■ | ■ | | ■ | | ■ | | | ■ | ■ | | | ■ |
| | Identity processes | "Masculine" identities | | ■ | | | | | | | ■ | | | | | ■ | |
| | | "Self-reliant" identities | | ■ | ■ | ■ | | | ■ | ■ | ■ | | ■ | | | ■ | ■ |
| | | "Old" identities | | | | | | | | ■ | | | | | | ■ | |
| | | Preferred identities | | ■ | | | | ■ | | | ■ | | | | | ■ | |
| | Problems with the acceptance of age-related changes | | | | ■ | ■ | | | ■ | ■ | | | | ■ | | | |

***Key: Filled squares** indicate that a study contained direct evidence for the corresponding theme. **Study code letters** correspond to those shown in Table 1.2. **Studies are ordered by quality** (critical appraisal outcome; see Methods) from high to low (left to right). Specifically, studies were first ordered by CASP-QR score and then by subjective ratings; this process takes both critical appraisal techniques into account but prioritises the subjective ratings, which were judged to be more reflective of overall study quality.*

Whilst the 17 themes showed relative independence, evidence suggested that they were also interrelated to varying degrees. For example, there were overlaps between biophysical barriers such as age-related disabilities and several other barriers including transportation problems and the perception of the neighbourhood as dangerous; thus, reduced social participation among older adults with disabilities was not a purely bio-physical process. To a certain extent, data supported a model of late life social participation in which biophysical, social, economic and psychological factors interact. For clarity of presentation in what follows, each of the seventeen themes will be presented individually; however, links between themes are acknowledged and discussed as appropriate.

## 1. Biophysical

### *1. 1 Biophysical barriers*

In most of the studies reviewed, including those of both high and low quality, participants explained their reduced social participation in terms of physical health problems that prevented them from moving around the neighbourhood. Specific problems mentioned included: arthritis, back problems, knee problems, restricted mobility, diabetes, hypertension, hearing and visual impairments, and incontinence.

> *"I'm limited in myself because of my knees … if I had my legs and things there are a lot of things I would like to participate in." (M)*

Older adults also described the link between physical difficulties and reduced social participation in terms of diminished energy levels, which made activities and outings more effortful (J, M, WJ, WR, F).

> *"You have to get up and go which is a bit of an effort." (WJ)*

Three studies of medium quality (B, F, J) indicated that reduced physical mobility led older people to avoid walking out into their neighbourhoods because of a perceived vulnerability to falling, especially in poor weather conditions.

## 2. Social

### *2. 1 Loss of pre-existing social contacts*

Many of the reviewed articles indicated that the loss of pre-existing social contacts was associated with gradual reductions in social participation. In general, studies tended to emphasise connections with partners, friends and neighbours more than connections with family, suggesting that the former groups of people may be more important for social participation.

### *2.1.1 Loss of partners and friends*

Seven articles of high to low quality suggested that the loss of long-standing partners and friends led to diminished levels of social participation. Evidence indicated that this was because close social contacts had previously acted as a "bridge" between individuals and social participation opportunities (H, J, WJ, WR). For example, some felt that they could not engage in activities as widows or without pre-existing friends:

> *"You don't go dancing without your husband … I am not going to go to a dance by myself" (J).*
>
> *"[Out of the] people I used to go around with over the years I've been here, there's only about two or three of us left. If they haven't moved out, they've passed on" (WJ).*

### *2.1.2 Loss of neighbourhood interactions*

Eight of the reviewed studies, ranging from high to medium quality, suggested that reduced social participation was linked to a general reduction in informal social interactions between neighbours (B, YE, YU, WR). This was in part attributed to high levels of local population turnover, which led to the loss of previously familiar neighbours (B, R, YU, WJ, WR). Moreover, older people said that newer residents were commonly younger and occupied by full-time work, which meant that they were rarely available for socialising in the community (YU).

> *"Most people who I knew around here are gone now. They either died or they moved away … In the old days, the neighbourhood was much more sociable. Now, there are a lot of new arrivals and we don't socialise with them. It's difficult." (B)*

Two of the studies suggested that the out-migration of previously familiar community members was a particular problem in relatively deprived neighbourhoods: older people with more resources seemed to leave in search of better lifestyles, whilst younger people with fewer resources arrived in search of cheaper housing (B, WJ). Additionally, new residents in these areas were sometimes perceived as disruptive (WJ).

> *"It used to be a quiet neighbourhood. It was a good neighbourhood, and then we got some neighbours that moved in and it's not a good neighbourhood now … They're into drugs and they drink a lot. They have lots of parties. She is very abusive and things like that." (WJ)*

Older adults also reported difficulties in forming connections with new residents from different ethnic and linguistic backgrounds, thus indicating racial tensions that led to fewer interactions between neighbours (B, G, YE).

> *"Cause you know Chinese people don't … Some of them don't talk to Black people." (YE)*

In further support of this assertion, older people who had recently migrated from other countries reported unwelcoming behaviour from longer-term residents (G).

> *"If you don't speak the language even your closest people will look down at you, they don't consider us as part of the society" (G).*

Thus, multiple social factors associated with local population turnover appeared to contribute to a reduction in interactions between neighbours. Perhaps in reflection of these factors, some older adults spoke directly of a lack of community cohesion and expressed nostalgia for a previous era during which they believed that the community had been more integrated (e.g. B, WR).

> *"It's a different era obviously and you don't now virtually have anything to do with your neighbours ... I think it is a sign of the times. Everybody's busy." (WR)*

### *2.1.3 Loss of family contact*

Four articles (high to low quality) suggested that a loss of contact with extended family contributed to older adults' reduced levels of social participation (H, J, M, WR). Older residents explained that they felt separated from their extended families that lived far away and were often too busy to visit. Evidence also suggested that older people felt that this separation reflected a perceived change in values, whereby the younger generation had less of an "extended family orientation" and instead prioritised other aspects of life such as work (J).

> *"But I do long for the closeness that we had of families when, every week, we were together with cousins and uncles and aunts and grandmas and grandpas. That hardly ever happens anymore because people move so much." (J)*

### *2.2 Caregiving duties*

Three studies of medium quality indicated that reduced social participation was associated with the onset of time-consuming caregiving duties at home, such as looking after a sick spouse or babysitting grandchildren (J, R, WJ). This difficulty was also associated with a lack of respite services for caregivers (R).

> *"What do I do for entertainment? Well my husband's old, eh! I don't do anything for entertainment, no. I'd like to be doing something but I can't leave him alone too long. He's sort of, losing it, it's hard on me, but this is why I can't be where I'd like to be at times." (R)*

### *2.3 Perception of the neighbourhood as dangerous*

Seven studies, including those of both high and low quality, indicated that older adults did not participate socially because they saw their neighbourhoods as dangerous places in which attacks, muggings and burglaries were commonplace (B, F, H, J, M, S, WR, YE). As a result, they avoided entering certain localities, particularly when alone or at night.

> *"I used to be very active in the neighbourhood committee. But now I don't go anymore. The meetings are always during the evening and since I was mugged one night, I don't go out after dark anymore." (B)*

Studies further indicated that older adults were particularly wary of crime because they believed they were less able to defend themselves due to a reduction in their own physical strength (B, S, YE). This tendency was particularly noted among men who avoided facing any threats to their strong masculine identities by staying at home at night (S).

> *"Since I've had my hip done I've always felt a bit wary. If anyone did actually try to attack me, I wouldn't be able to defend myself." (B)*

There was also evidence that older adults commonly associated danger in the neighbourhood with the presence of young people, and avoided spaces where youths typically congregate (YE, B).

> *"We used to have some kids walking around and not going to school and stuff like that. But I think that goes on all over. But the only time you're really kind of bothered with it is if you go up here at lunchtime when they're all out having lunch. But you learn to stay home and avoid it so, that's about it" (YE)*

### *2.4. Ageism*

Five studies, all within the medium to high quality range, suggested that ageist views prevalent in older adults' neighbourhoods contributed to their reduced social participation (WR, F, R, J). For example, some older people reported that they had been told that they were "too old" for certain social activities, and particularly paid work. Moreover, data indicated that some older adults had internalised these views such that they initiated their own withdrawal from social opportunities.

> *"I took an administration assistant course in computers. I went in debt for it, too, $10,000 to pay back … and they told me I was too old to do any more with it. I was very discouraged." (R)*
>
> *"People my age don't go dancing" (J)*

## 3. Material

### *3.1 Perceived lack of appropriate neighbourhood resources*

Almost all studies indicated that a perceived lack of appropriate neighbourhood resources led to reduced participation among many older adults. This under-provision was associated with a lack of funding, a lack of younger residents with the time and inclination to contribute to the running of services, the closure of local shops and facilities, and a lack of social provision in accessible buildings (i.e. with ramps for wheelchairs).

> *"I think we're all right, only thing is that you have to travel six miles to shop. There is no shop here at all. There's no pub, so we can't go and have a pint." (DW)*

Studies also indicated that many of the available social activities were unappealing to older adults (DW, J, M, R,).

> *"When they asked me to join, I said, I don't want to play silly games." (DW)*

Some older adults expressed an opinion that local organizations lacked commitment to local residents, or took little notice of "ordinary" people, which demotivated them from participating (G, S). Finally, one study (G) suggested that older adults do not participate because they have insufficient information about local services, and particularly, about the people who run them.

> *"No, I am not a member of organization. I have heard about, but never met with them and I've never seen them." (G)*

### *3.2 Transportation problems*

In most studies, ranging from high to low quality, older adults reported that public transport problems limited their ability to access social participation opportunities in the local area. In particular, they said that transport options were minimal, and did not accommodate their mobility difficulties (e.g. M, DW, WJ). Other studies highlighted the difficulties of losing access to a private car, which was particularly common among women following the death of a husband with a driving license (WJ, F, WR). As a result of these problems, older adults chose to stay at home, and therefore experienced diminished levels of social participation.

> *"Bus drivers don't stop. You know, they don't wait until you sit. They pull off and knock you back onto the floor." (M)*
>
> *"If [transport] gets too complicated it's better to stay at home." (F)*

### *3.3 Lack of personal financial resources*

Six studies of medium quality indicated that a lack of personal financial resources constituted a further barrier to social participation because associated costs (entrance fees, transport costs) were unaffordable.

> *"If it wasn't for the financial challenges, there might be some other things that the area offers, but we can't do it. I love to curl, and I'd love to go golfing with the boys. They ask me to go out all the time, but can't afford it." (R)*

Additionally, two studies indicated that individuals who have lived with limited financial resources for many years might fail to recognize even affordable opportunities because they have little previous experience of purchasing social activities (J, R).

> *"We've always lived fairly tight, we've never had a lot of extra money all of our lives … bills come first." (R)*

### ***3.4 Physical layout of neighbourhood***

Three studies of high to medium quality suggested that older adults linked reductions in social participation to the physical layout of their neighbourhoods. In particular, articles indicated that residents struggled to interact with their neighbours in both highly isolated rural locations and excessively busy urban environments (DW, WJ, WR).

## **4. Psychological**

Whilst the social themes above focused on the loss of pre-existing contacts, a range of psychological processes appeared to affect participants' abilities to form new social links in later life; thus current evidence suggests a dissociation between these processes.

### ***4.1 Lack of social skills and/or confidence***

Eight of the studies, including those of both high and low quality, suggested that older adults struggled to take advantage of new social opportunities because they lacked necessary social skills and/or confidence (H, J, R, WJ, WR, S). This scenario was often linked to a lack of previous or recent social experience, and was associated with the following groups of people: those with lower socio-economic status, who may not perceive or approach social participation opportunities readily due to limited previous experience (R); older men, who may have accrued limited social participation experience throughout their lives (S); and individuals who previously fulfilled demanding caregiving roles (e.g. looking after a sick spouse) and find themselves unable re-build social ties when their duties are lifted (e.g. after the death of a spouse; WJ).

> "I've been so many years [caring for my husband] that I've had nothing. I couldn't do anything. I had an empty life, didn't know anybody, didn't know what to do. I still feel that way at times." (WJ)

Other evidence provided more indirect support for a link between reduced participation and limited social skills/confidence. For example, some individuals admitted that they found the process of making new friends challenging (J). Others reported specific worries about joining new clubs, groups and communities (H, WR, R), including the possibility of encountering established "cliques", or "overbearing people". Additionally, one study indicated that older adults who move house might be particularly likely to experience a lack of social confidence in their new neighbourhood (R).

Finally, some individuals expressed a clear preference to be alone and a corresponding lack of interest in making new social contacts (M, H, WR, YE). Individuals explained this preference in various ways: as a longstanding character disposition (YE); as a desire not to start “from scratch” (WR); and as an attempt to avoid the repetition of previous experiences of loss and bereavement (H).

### *4.2 Identity processes*

Multiple studies of high, medium and low quality suggested that engagement in new social interactions was affected by the preferred self-descriptions, or identities, held by older adults. In particular, it appeared that participation diminished where social opportunities did not match and/or contradicted older adults’ preferred identities.

#### *4.2.1“Masculine” identities*

Three studies ranging from high to medium quality indicated that the social arena for older people was often viewed as a feminine space, and did not align with “masculine” identities, which typically involved being strong, capable of work, and self-sufficient. In particular, groups for older adults were often considered “feminine” because of the nature of activities offered, which frequently included “small-talk”, discussing problems, and games like bingo (S). Thus, a desire to protect masculine identities led to reduced attendance at groups for older adults among men (DA, DW, S).

> *“Yes, well that Day Centre isn’t for me. I’m afraid it’s for dear old ladies.” (DA)*
>
> *“More ladies than men go to the community centre … There is nothing actually for them [men] at the centre, they'd rather go for a pint and a chat to a pub or club, women aren't as bothered that way.” (S)*

### ***4.2.2 “Self-reliant” identities***

Within nine of the studies (ranging from high to low quality), older adults identified themselves as “self-reliant”, which was described as retaining independence, protecting one’s privacy, and refraining from asking for help (e.g. DA, DW, H, S, WJ, WR). Furthermore, older people appeared highly motivated to maintain these “self-reliant” identities due to a range of strongly held beliefs. For example, they commonly equated asking for help with being burdensome, weak, and even manipulative towards others (DW, F, J, M, S, WR, WJ).

> *“[asking for help is] using your friends and I don't work like that.” (S)*

Additionally, evidence indicated that older people valued stoicism (self-reliance even in the face of suffering; S, WJ, DW). For example, they thought that it was “up to them” (WJ) to deal with problems, and thus refrained from help-seeking and resigned themselves to tolerating difficulties alone (WR, WJ, J, YE).

Crucially, data suggested that the prospect of attending new social groups constituted a threat to older adults’ valued “self-reliant” identities, because they perceived attendance as a loss of independence and an admission of defeat (DA, DW, S, WJ). Thus, the valuation of “self-reliant” identities among older adults was associated with reduced uptake of new social opportunities.

> *“I wouldn’t be seen dead in a place like that – it means you’ve had it, you’ve given up.” (DA)*

### *4.2.3 "Old" identities*

Attendees at older people's social groups were frequently labelled as "old", which here meant being sick, incapacitated, cognitively impaired, and "waiting to die" (DA). Such processes appeared to reflect commonplace ageist beliefs that stereotype and stigmatise older people (Angus & Reeve, 2006; Bytheway, 1995; Dillaway & Byrnes, 2009; Hurd, 1999; Minichiello, Browne, & Kendig, 2000; Nelson, 2002, 2005; Nussbaum, Pitts, Huber, Krieger, & Ohs, 2005). Evidence from two medium-quality studies suggested that individuals resisted participation in older adults' groups partly because they did not want to adopt a stigmatised "old" identity (DA, J).

> *"It was depressing to see these elderly people. I can't go there anymore." (J)*

In further support of this view, studies suggested that those who construed themselves as "lively", which here meant retaining a degree of health, activity, and interest in life, were particularly resistant to partaking in older adults' activities and adopting an "old" identity (DA).

> *"Well I wouldn't expect to find lively company there and I would like lively company please." (DA)*

### *4.2.1 Preferred identities*

In four articles, ranging from high to medium quality, there was evidence that older adults refrained from joining social activities because opportunities did not support preferred aspects of their identities (DA, DW, R, S). These preferred identities typically related to roles and interests that individuals had developed within occupational or social arenas over the course of many years; for example, being a local handy-man, or a golf-club member. Evidence suggested that groups that reflected long-standing interests were perceived to be “just like a normal club” (DA) because they aligned with preferred identities; however, clubs specifically for older people were heavily stigmatised and contradicted preferred identities. In particular, “normal” clubs provided older people with a forum in which to pursue meaningful and useful goals that bolstered their preferred identities, whilst “old folks’ clubs” were perceived to encourage the performance of meaningless and useless activities that threatened their preferred identities and were therefore avoided (DA).

> *“I’ve never played bingo. Maybe I’m missing something … I worked as a bookkeeper, I became a parts man, I sold parts for tractors, etc. I had a reputation of being a very good parts man.” (R)*

### *4.3 Problems with the acceptance of age-related changes*

Five articles, ranging from high to low quality, suggested that older adults often experience problems with the psychological acceptance of age-related changes (e.g. illness, disability, bereavement). At one extreme, several studies indicated that older people often display psychological resignation to such changes; moreover, this *over-acceptance* seemed to mean that they did not attempt to adapt to changes in order to stay socially engaged.

> *“I don’t waste my time wishing for things that I’m not able or can’t do … I used to waste an awful lot of time on daydreams. And I got over that, and now, what is, is.” (J)*

At another extreme, one article of medium quality (F) suggested that older adults sometimes fail to accept age-related changes. The quote below suggests that such *under-acceptance* may lead individuals to withdraw from social activities, because they feel that they can no longer perform as they did previously.

> *"The tough part is to change your thoughts and realise that you are no longer 25 and can't perform things the way you are used to. And that's difficult for me. I still want to be the best." (F)*

Although evidence here is limited, these findings might indicate that the over- or under-acceptance of age-related changes leads to reduced social participation.

## Discussion

Reduced social participation among older adult populations poses a significant public health problem (e.g. Glass, de Leon, Marottoli, & Berkman, 1999; Bennett, 2002); however, little is known about the mechanisms that underlie this phenomenon. Previous research has tended to prioritise the measurement of researcher-defined constructs, and might therefore be augmented by the examination of subjective experiences. Thus, the current study aimed to review literature describing older adults' subjective experiences of barriers to social participation. Thematic Analysis (Braun & Clarke, 2006) was used to review 15 studies. Data was organised into 17 themes, which were then grouped into 4 overarching categories of barriers to social participation: *Biophysical, Social, Material, and Psychological* (see Table 1.3). The identified themes converged with existing literature, but also augmented previous knowledge. In particular, findings suggest a range of hypotheses concerning mechanisms of reduced social participation in later life that should be tested in future research.

The biophysical, social and material themes in the present review are particularly well supported by previous work. For example, a range of evidence suggests that biophysical factors (e.g. age-related illnesses and disabilities) pose important barriers to social participation (e.g. Adamson et al., 2004; Bukov et al., 2002; Lefrancois et al., 1997; Levasseur et al., 2011; Richard et al., 2009; Wilkie et al., 2007). Similarly, prior work suggests that reduced participation may be related to social factors including the loss of contact with friends and neighbours (and to a lesser extent family members) due to illness, disability, death and/or migration, and neighbourhood indicators such as subjective pleasantness ratings (e.g. Pollack & von dem Knesebeck, 2004; Bowling & Stafford, 2007). Additionally, pre-existing literature describes links between a lack of personal and/or community material resources, and reduced participation (e.g. Bowling & Stafford, 2007; Bukov et al., 2002; Pollack & von dem Knesebeck, 2004; Wilkie et al., 2007). Whilst these convergences help to confirm the validity of the present review, it is perhaps of greater interest that current findings moved beyond previous work to suggest additional factors; these will therefore comprise the focus of this discussion.

**Social barriers**

Several new hypotheses concerning barriers to social participation in later life were generated here within the *social* theme. Firstly, evidence suggested that the loss of partners and friends led to reduced participation not only because of the absence of these valued interaction partners, but also because older people felt unable to join community groups alone. Secondly, although evidence was relatively weak, findings indicated that preoccupation with caregiving tasks in the home (e.g. looking after a sick spouse) precluded social interaction outside the home; this suggestion falls in line with other research indicating that caregiving can have a negative impact on health (e.g. Schulz & Martire, 2004; Vitaliano, Zhang & Scanlan, 2003). Thirdly, data indicated that high levels of local population turnover posed particularly important barriers to participation, due to the associated loss of everyday interactions with neighbours; moreover, this seemed to be a particular problem in areas with high unemployment and economic deprivation. Fourthly, current evidence strongly suggested that prevalent perceptions of the neighbourhood as dangerous impeded social participation among older people; in particular, individuals were afraid of being attacked, mugged or burgled. Fifthly, although evidence was again relatively weak, this review suggested that ageist stereotypes of older people (e.g. Angus & Reeve, 2006; Bytheway, 1995; Dillaway & Byrnes, 2009; Hurd, 1999; Minichiello et al., 2000; Nelson, 2002, 2005; Nussbaum, Pitts, Huber, Krieger, & Ohs, 2005) were commonplace within the studied neighbourhoods and led to reductions in late life social participation; specifically, a widespread belief that people lose capacity to participate by virtue of age alone, propounded not only neighbourhood residents but also by older adults themselves (e.g. Hurd, 1999; Minichiello, Browne & Kendig, 2000), was here associated with reduced social participation. Each of these hypotheses will require development and clarification in future research. In particular, given that the social processes identified here traversed individual, neighbourhood and societal levels, studies might seek to utilise mixed methods that can capture a broad range of factors in parallel.

### Material barriers

Several new hypotheses concerning barriers to social participation were also generated within the *material* theme. Firstly, almost all studies indicated that older adults felt that community resources were limited in number, lacking in appeal, and difficult to access due to inappropriate public transport. Secondly, evidence indicated that features of neighbourhood layout, such as rural isolation or urban density, impeded social participation; although this evidence was relativity weak, it tallies with literature about the practical difficulties that older people face when negotiating rural (Wenger, 2001) or urban environments (Li, Fisher, Brownson & Bosworth, 2005; Buffell, Phillipson & Sharf, 2012). Thirdly, current findings provided new insights into links between limited personal financial resources and reduced social participation. For example, it suggested that individuals with limited economic resources were not only unable to afford social participation opportunities, but also failed to recognize even affordable opportunities; such results thereby indicated the potential importance of factors such as the salience and perceived affordability of social participation opportunities. Fourthly, this review suggested that individuals with fewer material resources were more affected by non-material barriers to participation than others. For example, they reported less community cohesion and therefore enjoyed fewer interactions with neighbours. Additionally, they reported more difficulties with accessing social opportunities due to a lack of social skills and/or confidence. Taken together, these observations converge with a large body of health inequality research that describes links between financial disadvantage and poor health outcomes both across the life-span (e.g. Marmot et al., 1991; Marmot, 2002), and in later years (Coote, 2009; Grundy & Sloggett, 2003; Huisman, Kunst, & Mackenbach, 2003; Marmot & Shipley, 1996). Importantly, this literature suggests that such associations are mediated by individual disempowerment (Marmot, 2007), a factor which has been empirically associated with low levels of social engagement in previous research (Zimmerman & Rappaport, 1988). Taken together, these findings strongly suggest that economic resources, and the associated concept of power, should be foregrounded when investigating reduced social participation among older people.

### Psychological barriers

The identification here of *psychological* barriers to late life social participation was particularly novel and thus of particular interest. The first psychological factor, for which there was moderate evidence, comprised a lack of social skills and/or social confidence, which led older adults to under-utilise participation opportunities. Although such problems have not been previously linked to social participation, they have been linked to the closely related concept of loneliness, which refers to the distressing state associated with a perceived discrepancy between actual and desired social interactions (e.g. Victor et al., 2000). In particular, research suggests that loneliness is maintained by maladaptive cognitive and behavioural processes that lead individuals to expect and elicit negative social interactions (Hawkley, Preacher, & Cacioppo, 2007; Hawkley, & Cacioppo, 2010). Given conceptual and empirical overlaps with loneliness (e.g. Victor et al., 2000), it is plausible that reductions in late life social participation might reflect similar processes. Here, it might be hypothesised that negative beliefs about social interactions could emerge during transient experiences of social isolation associated with age-related life events (e.g. bereavement, caregiving), leading to a long-standing lack of social participation. Additionally, whilst it is unlikely that reductions in late life social participation are a simple reflection of social skill deficits, it is plausible that those with weaker social skills might struggle to adapt to new social environments during the ageing process, such that they experience reduced social interactions. In the future, longitudinal studies will be required to examine these hypotheses and describe the associations and temporal links between social cognitions, behaviours, and skills, and social participation.

The second psychological factor identified here comprised processes of identity, which can be defined as the sets of characteristics that individuals attribute to themselves to achieve a coherent self-concept (Oyersman, Elmore, & Smith, 2012). Overall, findings provided moderate evidence that social participation diminished where perceptions of community groups did not align with older adults’ preferred identities. This process manifested here in four different ways. Firstly, social opportunities were commonly regarded as “feminine”, and this led to the under-participation of men who feared losing their valued “masculine” identities. Secondly, older adults commonly identified themselves as “self-reliant”, and avoided attendance at social groups because they believed that this would threaten their independence and label them as weak and failing; this process was particularly prevalent among men, who viewed self-sufficiency as a facet of masculinity. Thirdly, commonplace ageist beliefs which stigmatise the ageing process (e.g. Bytheway, 1995) appeared to limit social participation via identity mechanisms: in particular, people resisted participation in older adults’ groups because they did not want to be labelled as “old”, which was typically taken to mean incapacitated. Fourthly, older adults seemed to avoid participation because available social opportunities did not align with preferred aspects of their identities. For example, individuals with particular occupational or social identities (e.g. handy-man, golf-club member) shunned participation in generic older adults’ groups that contradicted these identities.

These findings converge with a large body of research that links *social identity* (Tajfel & Turner, 1979), the sense of self that individuals derive from their group memberships (e.g. man, father, engineer, footballer, Catholic), with beliefs and behaviours (St Claire & He, 2009; Jetten, Haslam, & Haslam, 2012). In particular, studies show that social identity affects service utilisation: help is more likely to be sought and accepted if a receiver judges that they share a positively connoted and valued social identity with a provider (Haslam, Jetten, O’Brien, & Jacobs, 2004; Haslam, O’Brien, Jetten, Vormedal, & Penna, 2005; Haslam, Reicher, & Levine, 2012; Levine, Prosser, Evans, & Reicher, 2005). Furthermore, individuals make attempts to align themselves with groups that represent valued social identities, and avoid association with those that do not, in order to build self-esteem (Abrams & Hogg, 1988; Oakes & Turner, 1980; Tajfel & Turner, 1979). Thus, the identity processes noted in this review may reflect older adults' attempts to use their social participation choices to maintain their preferred identities, and boost their self-esteem. Moreover, since many available social participation opportunities conflicted with older adults' preferred identities, identity processes here appeared to lead to reductions in social participation. Given that 10 out of the 15 studies reviewed contributed to these ideas, it can be suggested that future studies should seek to develop understandings of the impact of identity processes upon late life social participation.

The third and final psychological theme, for which there was moderate support, suggested that social participation might reduce when older adults either fail to accept (*under-accept*), or become resigned to (*over-accept*) age-related changes including illness, disability or bereavement. This prediction falls in line with a model of *adaptation* proposed by Brandtstädter and colleagues, as well as evidence linking adaptation to wellbeing in later life (Brandtstädter & Greve, 1994; Brandtstädter & Rothermund, 2002; Rothermund & Brandstädter, 2003). Current evidence might suggest that older adults who have problems with either under- or over-acceptance of age-related changes fail to adapt their previous socialisation strategies and therefore experience reduced levels of participation. Importantly, adaptation processes are likely to interact with the other barriers described in this review; for example, adaption to disability, bereavement or an ageing identity (for a model of identity adaptation in later life, see Sneed & Whitbourne, 2001; Whitbourne, 1996; Whitbourne & Collins, 1998). Thus, although specific evidence here was limited, adaptation processes may play an important role in late life social participation and should be examined in future work.

## Limitations

The current study was subject to several limitations. Of note, the systematic search retrieved only 15 articles that met criteria for the current review; therefore current findings are limited by the somewhat restricted information contained within the retrieved studies. Additionally, it was felt that the review process did not reach "saturation", defined as the point in qualitative analysis after which additional data does not lead to the generation of new ideas or themes (Charmaz, 2006). Specifically, although studies shared many themes in common, most generated new themes, and this suggested that additional conclusions could have emerged if more studies had been available to review. Moreover, the studies were of varying quality, ranging from relatively high to relatively low; whilst some presented full accounts of methodological procedures and richly contextualized findings, others were less clear. To address these difficulties, a critical appraisal tool was employed, to avoid excluding articles from the small pool identified whilst ensuring that the quality of evidence was as transparent as possible. Whilst this approach allowed the reader to judge the credibility of themes for themselves, it remained possible that conclusions were biased by the inclusion of poorer quality studies. Additionally, none of the retrieved studies acknowledged or accounted for bias introduced by researchers' pre-existing beliefs and experiences. Lastly, whilst the studies included participants from a range of backgrounds (high and low socio-economic backgrounds, rural and urban environments, and differing ethnicities including African, Asian and Latino), their findings did not provide particular insights into any cultural variations in late life social participation. In spite of these problems, the group of reviewed articles appeared to generate relatively rich insights into older adults' experiences of barriers to social participation.

## Conclusions

Taken together, current results indicate that barriers to social participation in later life include a range of biophysical, social, material and psychological factors and thus traverse multiple and diverse levels from the individual to the societal. Indeed, this finding dovetails with recent studies, which indicate that wellbeing in later life is best predicted by multi-dimensional models that incorporate wide-ranging constructs including: physical, cognitive, psychological, social, coping, economic, perceived neighbourhood environment and overall life satisfaction (Bowling & Iliffe, 2006; Bowling, 2007). It is argued that such models are preferable partly because they are not restricted to a particular view of what constitutes "successful ageing", and additionally take older peoples' own constructs of wellbeing into account (Bowling, 2007). Indeed, it is noteworthy that novel hypotheses were generated in the current study through the examination of older adults' own accounts of their experiences; this suggests that researchers may benefit from paying as much attention to lay views as to professional theories (Bowling, 2007). More specifically, current findings delineated several novel areas of inquiry that future research into late life social participation might prioritize, such as: neighbourhood problems including population turnover and perceived danger; the impact of ageism; the influence of economics and power; social skill and confidence problems; identity processes; and adaptation to age-related changes.

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# Part 2: Empirical Paper

# A qualitative study of barriers to social participation among lonely older adults: the influence of social fears and identity

## Abstract

***Introduction.*** *Loneliness among older adults is a major public health problem that may be associated with processes of social participation and identity. This study therefore sought to examine the relationship between social participation and identity in a sample of lonely older adults living independently in London, England.* ***Method.*** *An inductive qualitative approach, based on semi-structured interviews and Thematic Analysis (Braun & Clarke, 2006), was employed.* **Results.** *Participants commonly spoke of barriers to social participation that have been reported elsewhere, including illness/disability, loss of contact with friends/relatives, lack of a supportive community, and lack of acceptable social opportunities. However, novel findings were also derived. In particular, participants commonly minimised the difficulties they faced alone, and described attempts to avoid social opportunities. These behaviours were linked to fears about engaging in social participation opportunities, including fears of social rejection and/or exploitation, and fears of losing valued aspects of identity.* **Discussion.** *It is concluded that social participation amongst lonely older people will not improve through the removal of previously reported barriers alone; instead, older peoples' beliefs, fears and identities must be addressed. Suggestions for implementing these findings within community organisations are provided.*

## Introduction

Loneliness among older adults is recognized as a major public health problem (e.g. Department of Health, 2012a). Evidence points to associations between late life loneliness and reductions in social participation (e.g. Victor, Scambler, Bond, & Bowling, 2000). Whilst mechanisms leading to reduced social participation are poorly described, literature indicates the potential influence of identity processes (Jetten, Haslam & Haslam, 2012; St Claire & He, 2009). Thus, the current study examined the relationship between social participation and identity in a sample of lonely older adults living independently in London, England. In what follows, each of the main concepts addressed here (loneliness, social participation, identity) will be defined, and their inter-relationships will be illustrated with supporting evidence, thus providing a rationale for the current study.

### Loneliness

Social isolation refers to an objective lack of social interactions in everyday life (Victor et al., 2000). Loneliness is a related but distinct concept that describes the subjective experience of social isolation, or more precisely, the distress that accompanies a deficit in actual compared to desired social relationships (Luo, Willen, Hawkley, Waite, & Cacioppo, 2012; Masi, Chen, Hawkley, & Cacioppo, 2011; Pinquart & Sorensen, 2001; Victor, Scambler, Bowling, & Bond, 2005; Victor et al., 2000).

Empirical evidence suggests that older adults, in comparison to people of other ages, experience increased levels of loneliness (e.g. Dykstra, van Tilburg & Gierveld, 2005;

Victor & Yang, 2011), with prevalence estimates ranging from 10 to 50% (Victor et al., 2005; Victor et al., 2000; Victor, Burholt, & Martin, 2012). Moreover, a growing literature indicates that older adults who experience loneliness are more likely than their peers to experience poor physical and mental health outcomes, and an earlier death (Cacioppo, Hawkley, & Thisted, 2010; Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Cacioppo & Hawkley, 2009; Hawkley & Cacioppo, 2010; Holt-Lunstad, Smith, & Layton, 2010; Luo et al., 2012; Penninx et al., 1997; Sugisawa, Liang, & Liu, 1994; Thurston & Kubzansky, 2010; Wilson et al., 2007). Therefore, late life loneliness is increasingly recognized as a major public health problem by both statutory and non-statutory organizations (e.g. Department of Health, 2012a; Department of Health, 2012b; http://www.campaigntoendloneliness.org).

Mechanisms underpinning late life loneliness are so far poorly described, partly because they are likely to be complex and multi-factorial (e.g. involving a combination of cognitive, behavioural, affective and social factors), and partly because research efforts are impeded by commonplace difficulties in recruiting lonely older participants (e.g. Dickens et al., 2011; Ollonqvist et al., 2008; Saito, Kai, & Takizawa, 2012). Nevertheless, a small body of literature has delineated factors that moderate the risk of loneliness, including: poor health/disability, the death of a partner, living alone, lower activity levels, loss of social contacts and lack of access to appropriate transport (Jylha et al., 2004; Pinquart & Sorenson, 2001; Victor et al., 2005; Victor et al., 2000). Additionally, longitudinal studies have sought to examine the development of loneliness and findings highlight the importance of *relative losses* in health and social status over time rather than absolute levels of these resources (Aartsen & Jylhä, 2011; Victor & Bowling, 2012; Dykstra et al., 2005). However, this work is preliminary and much further research is required before the current epidemic of late life loneliness can be fully addressed.

## Social Participation

Given this limited understanding, it might be helpful to examine other processes that likely contribute to late life loneliness, such as reduced *social participation*. Definitions of social participation vary (Levasseur, Richard, Gauvin, & Raymond, 2010); however, it is commonly regarded as an individual's involvement in interpersonal interactions outside of the home, including leisure pursuits with others, social group participation, neighbourhood activism, and paid or voluntary work (Levasseur et al., 2011; Maier & Klumb, 2005). In later life, whilst limited reductions in social participation may carry certain benefits (Carstensen, Fung & Charles, 2003), compelling evidence suggests that significant reductions should be considered problematic because they are associated with physical and mental illnesses and increased mortality (e.g. Glass, de Leon, Marottoli, & Berkman, 1999; Glass, de Leon, Bassuk, & Berkman, 2006).

A range of evidence indicates links between late life loneliness and reduced social participation. For example, like loneliness, reduced social participation is common in older adult populations (Bowling & Stafford, 2007; Bukov, Maas, & Lampert, 2002; Desrosiers et al., 2009; Desrosiers, Noreau, & Rochette, 2004; Pollack & von dem Knesebeck, 2004; Victor et al., 2000) and is associated with similar negative health outcomes (Bassuk, 1999; Beland, Zunzunegui, Alvarado, Otero, & del Ser, 2005; Bennett, 2002; de Leon, 2003; Fabrigoule et al., 1995; Glass et al., 1999; Glass et al., 2006; Glei et al., 2005; Hsu, 2007; Lennartsson & Silverstein, 2001; Maier & Klumb, 2005; Menec, 2003; Nakanishi & Tatara, 2000; Pollack & von dem Knesebeck, 2004; Walter-Ginzburg, Blumstein, Chetrit, & Modan, 2002; Wang, 2002). Additionally, limited evidence indicates that interventions to increase social participation may lead to reductions in loneliness (Masi et al., 2011). Finally, since longitudinal studies suggest that that loneliness is predicted by reductions in health (e.g. the onset of illness/disability) and/or reductions in social resources (e.g. the loss of friends/family) over time (Aartsen & Jylhä, 2011; Dykstra et al., 2005; Victor & Bowling, 2012), it might be hypothesised that loneliness is associated with difficulties maintaining previous levels of social participation following health and/or social losses. Taken together, links between late life loneliness and reduced social participation suggest that it may be interesting to explore the uptake of social opportunities among lonely older people.

Previous research has delineated risk factors for reduced social participation in later life, including: higher age, illness/disability, lower socioeconomic status, lower educational/occupational attainment, ethnic minority status, lower subjective ratings of neighbourhood factors (e.g. resources/accessibility/pleasantness), and reduced social contacts (Adamson, Lawlor, & Ebrahim, 2004; Barnes, de Leon, Bienias, & Evans, 2004; Bowling & Stafford, 2007; Bukov et al., 2002; Lefrancois, Leclerc, & Poulin, 1997; Levasseur et al., 2011; Pollack & von dem Knesebeck, 2004; Richard, Gauvin, Gosselin, & Laforest, 2009; Wilkie, Peat, Thomas, & Croft, 2007).

Additionally, as described in Part 1 of this thesis, qualitative studies have begun to describe older adults' subjective experiences of barriers to social participation, highlighting the following factors: illness/disability, loss of contact with friends/family/neighbours, perceptions of the neighbourhood as dangerous, preoccupation with caregiving, ageist beliefs that older people cannot participate, lack of personal financial resources, lack of social skills/confidence, lack of social opportunities that support preferred identities, and difficulties adapting to age-related changes (Andonian & MacRae, 2011; Buffell, Phillipson, & Scharf, 2012; Davidson, Daly, & Arber, 2003; Dwyer & Hardill, 2010; Fristedt, Björklund, Wretstrand, & Falkmer, 2011; Gele & Harsløf, 2012; Jansen, 2005; Martinez, Kim, Tanner, Fried, & Seeman, 2009; Rozanova, Keating, & Eales, 2012; Sixsmith & Boneham, 2003; Walker et al., 2012; Walker & Hiller, 2007; Yen et al., 2012; Yuan & Ngai, 2012). However, these studies are of varying quality and their preliminary findings require validation and development in further research.

## Social Participation and Social Identity

A separate body of literature proposes that reduced social participation in later life may be mediated by processes of identity, and in particular, social identity. The term *identity* describes the sets of characteristics that individuals attribute to themselves, and which contribute to a coherent self-concept (Oyserman, Elmore, & Smith, 2012). Individuals typically possess multiple identities simultaneously, and these can be subdivided into two broad types: personal and social. *Personal identities* are based upon individuating traits, i.e., qualities that make one different to others (Oyserman et al., 2012), such as seeing oneself as shy, liberal, clever, or creative. In contrast, *social identities* are derived from group memberships, and therefore comprise qualities that make one the same as others (Oyserman et al., 2012; Tajfel & Turner, 1979; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987; Turner, Oakes, Haslam, & McGarty, 1994), for example, identifying oneself as a woman, wife, teacher, hill-walker, or Christian.

A well-established literature demonstrates strong links between social identity and utilisation of healthcare services (e.g., Jetten et al., 2012). For example, studies show that healthcare is more likely to be accepted if a receiver judges that they share a social identity with a provider, because participation reinforces a valued identity and boosts self-esteem (Haslam, Jetten, O'Brien, & Jacobs, 2004; Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Haslam, Reicher, & Levine, 2012; Levine, Prosser, Evans, & Reicher, 2005). The converse situation, in which a receiver judges that they do not share a social identity with a provider, is thought to lead to refusal of services because the maintenance of a valued identity is threatened. Applying these ideas to late life social participation, an older person who describes himself as a "bloke" may not wish to attend a group that is mainly attended by women, because this contradicts his male identity. Alternatively, an older person who identifies as a "care-provider" may not attend a support group in case they become seen as a "care-recipient". Moreover, given the widespread stigmatisation of ageing (Angus & Reeve, 2006; Bytheway, 1995; Dillaway & Byrnes, 2009; Hagestad & Uhlenberg, 2006; Hagestad & Uhlenberg, 2005; Hurd, 1999; Minichiello, Browne, & Kendig, 2000; Nelson, 2002, 2005; Nussbaum, Pitts, Huber, Krieger, & Ohs, 2005; Palmore, Harris, & Branch, 2005; Phillipson & Biggs, 1998), these processes may lead individuals to avoid participation in groups for older adults in case they become identified as “old” (St Claire & He, 2009). As noted above, preliminary qualitative evidence suggests that participation among older adults is reduced when social opportunities do not reflect their preferred identities, thus providing tentative support for these ideas (Davidson et al., 2003; Dwyer & Hardill, 2010; Rozanova et al., 2012; Sixsmith & Boneham, 2003).

### Study aims

It may be hypothesised that mismatches between available interaction opportunities and older people’s preferred social identities contribute to reduced social participation. Furthermore, such associations might be particularly relevant in lonely older people, and in Western societies where old age is stigmatised. Thus, the current study sought to examine the relationship between social participation and social identities in a sample of lonely older adults living independently in London, England. Whilst reduced social participation in later life has been previously studied from various perspectives as described above, the current study is unique in its focus on lonely individuals, and its consideration of social identity. An inductive approach, based on semi-structured interviews and qualitative data analysis, was chosen in view of the limited knowledge of this topic to date. The specific questions asked were as follows:

1. What are the barriers that prevent lonely older adults from accessing opportunities for social participation?

2. How do lonely older adults respond to these barriers?
3. How, if at all, are these barriers and responses related to their social identities?

## Methods

### Setting

Recruitment took place via voluntary sector organisations situated in urban and multicultural boroughs of inner-city London (within the M25 motorway boundary), as follows: (i) three separate Age UK organisations, all of which operate as local independent charities to support older adults via campaigning, research, training, and local service provision; (ii) an independent charity that provides a befriending service for older adults (which remains anonymous for reasons of confidentiality).

### Ethical approval

Ethical approval for the study was obtained from the University College London Research Ethics Committee (see Appendix).

### Procedure

Staff at each of the charitable organisations were asked to identify suitable individuals meeting the inclusion criteria given below. Due to commonly acknowledged difficulties in recruiting lonely older research participants (e.g. Dickens et al., 2011; Ollonqvist et al., 2008; Saito et al., 2012), a convenience sampling approach was used (such that the first available individuals were recruited) and inclusion criteria were purposely flexible (in order to maximise the number of individuals that staff might refer to the study). Staff were asked to cease recruitment when the author felt that (i) a rich data set had been acquired, and (ii) additional interviews were adding little novel information.

Inclusion Criteria

1. Aged 60 years or older;
2. Previously or currently in receipt of any service from one of the charitable organizations involved in the study;
3. Judged by staff to be currently accessing none or subjectively few opportunities for social participation;
4. Judged by staff to experience loneliness and/or social isolation;
5. Able to communicate in spoken English to a level sufficient for participation in an interview (fluency not required).

Staff introduced the study to suitable individuals using a recruitment leaflet (see Appendix). During this process, staff were asked to refrain from using the term *lonely*, in case associated stigma led individuals to refuse participation (Victor et al., 2005). Where permission to be contacted by the research team was granted, the author telephoned individuals to give more details and to check that they were eligible and willing to participate, and able to give informed consent (Mental

Capacity Act, 2005). Where these conditions were fulfilled, the author arranged to visit the individual’s home on a subsequent day.

At the beginning of research visits, the author read the study information sheet (see Appendix) with participants, and allowed ample time for questions. She then re-checked that participants were still willing to take part and verified that they could give informed consent, before asking them to complete a consent form (see Appendix), and beginning the interview. Interviews were audio-recorded and lasted between 60 and 90 minutes. After the interviews, participants were invited to verbally provide a range of demographic information (age, ethnicity, details of any illnesses and/or disabilities, occupational history; see interview schedule in Appendix) and to complete a range of quantitative measures (see below and Appendix). If at any point the interviewer became aware of any potential risk issues (e.g. suicidal ideation in the context of severe depression), she paused the interview, determined the immediacy of risk through open discussion with the participant, and took action as agreed with the UCL ethics committee. Specifically, if risk was significant and urgent, the interviewer would contact immediately emergency medical/social care services, and subsequently inform the referring agency (e.g. Age UK). Alternatively, if risk was significant but non-urgent, the interviewer would discuss available support options with the participant, and if they gave consent, inform the referring agency who could then facilitate support-seeking as appropriate. Participants were compensated for their time with a £10 gift voucher for a supermarket of their choice, funded by University College London.

### Interview

A semi-structured interview was developed, based on the research questions and in line with relevant methodological guidelines (Smith, 1995); the full interview schedule is provided in the Appendix. The overall aim was to develop a rich understanding of those aspects of the participants' internal worlds that related to the research questions. The process of interview development was as follows: (i) determine research questions based on existing literature (as described in the introduction); (ii) for each research question, determine range of topics to be explored; (iii) for each topic, develop multiple questions for inclusion in the interview; (iv) establish ordering of questions, to support both the development of rapport at early stages, and the exploration of potentially sensitive topics (e.g. experiences of loneliness) at later stages; (v) use interview schedule and make adjustments according to participant feedback. A semi-structured approach was chosen in order to achieve a balance between researcher- and participant-driven content. The developed interview schedule was divided into four sections: (i) the first aimed to elucidate participants' social identities; (ii) the second aimed to examine perceived barriers to social participation, responses to these barriers, and how these might be influenced by social identity; (iii) the third aimed to find out about the types of social participation opportunities that participants might ideally wish for; (iv) the fourth aimed to examine participants' responses to loneliness, and how these might be influenced by social identity. To maximise alignment with research questions, the interview schedule was refined over the course of the first three interviews in the following ways: a new section was added (part iii above), and sub-questions were simplified and designated as optional rather than essential. In order to minimise bias throughout the interview process, the author attempted to use open questions at all times, and to create an informal conversational atmosphere in which the participant felt as comfortable and empowered as possible (Roulston, 2010).

### Quantitative measures

Participants were asked to complete three validated self-report measures as follows (see Appendix for full versions):

1. de Jong-Gierveld Loneliness Scale (full 11 item version; de Jong-Gierveld & Kamphuis, 1985)

This standardised scale was used to classify each participant's level of loneliness as moderate, severe, very severe, or not lonely.

2. Practitioner Assessment of Network Typology (Wenger, 1991)

This validated tool was used to provide objective information about participants' levels of social interaction. Specifically, it classifies older people's social networks (i.e. the networks of people with whom they regularly associate) into one of five *network typologies*, based on information about (i) proximity to family members, (ii) frequency of contact with family/neighbours/friends, and (iii) attendance at religious/social meetings. The five typologies (and their main constituent features) are: *Family Dependent* (FD; small network, mainly local family); *Locally Integrated* (LI; large network, family/friends/neighbours); *Local Self-Contained* (LSC; small network, household-centred, neighbours, distant family); *Wider Community Focused* (WCF; large network, friends, distant kin); *Private Restricted* (PR; small network, no local informal interactions).

3. Geriatric Depression Scale (short 15 item version; Sheikh & Yesavage, 1986)

Given that loneliness is a specific risk factor for depression (Cacioppo et al., 2006), and that depression affects service uptake among older adults (Beekman, Deeg, Braam, Smit, & Van Tilburg, 1997; Crabb & Hunsley, 2006), this scale was employed to classify each participant's level of depression as mild, moderate, severe, or not depressed.

Additionally, participants' socioeconomic status (SES) was estimated in two ways:

4. Standard Occupational Classification (SOC; Office for National Statistics, 2010a)

Occupation is widely considered a useful, if imperfect, proxy for SES (e.g. Galobardes et al., 2006). The SOC classifies jobs into 9 categories, according to associated levels of qualifications, training, skills and experience. The categories are as follows: 1 - Managers, Directors and Senior Officials; 2 - Professional Occupations; 3 - Associate Professional and Technical Occupations; 4 - Administrative and Secretarial Occupations; 5 - Skilled Trades Occupations; 6 - Caring, Leisure and Other Service

Occupations; 7 - Sales and Customer Service Occupations; 8 - Process, Plant and Machine Operatives; 9 - Elementary Occupations. Where a participant reported a spouse with an occupation associated with higher levels of training/experience, this was recorded since it was assumed to be a better indicator of the couple's overall SES.

5. Neighbourhood deprivation statistics (Office for National Statistics, 2010b )

National data, taken from the ONS Neighbourhood Statistics website (http://www.neighbourhood.statistics.gov.uk/dissemination/), were used as an index of neighbourhood economic deprivation. The particular statistic employed was an estimate of the percentage of working age individuals claiming a key benefit in the residential area immediately surrounding each participants' home (average size of area = 1500 residents). Data were derived in the following way: each participant's postcode was entered, the option of *Lower Layer Super Output Area* was selected, and the statistic labelled as *All People of Working Age Claiming a Key Benefit* was recorded (found under the section labelled *Key Figures for Economic Deprivation*).

### Analysis

Data analysis was performed using Thematic Analysis (TA; Braun & Clarke, 2006), situated within the epistemological framework of Constructivist Grounded Theory (CGT; Charmaz, 2006). CGT is a theory of socially constructed meanings; accordingly, it holds that personal belief systems and social (inter)actions shape one another in a continual, reciprocal, and dynamic fashion. Additionally, CGT recognises that social action goes beyond inter-individual relationships, and that personal meanings are influenced by contact with societal (cultural, political, economic) systems. CGT argues that the continual dynamic co-creation of meaning and action leads to evolving and potentially limitless subjective perspectives within any given situation, rather than any single “truth”. Thus, researchers who adopt this perspective aim to elucidate participants’ meanings through careful attention to, and interpretation of, what they say *and* do. Adopting a CGT perspective also encourages researchers to hold a reflexive stance, in which they consider the impact of their own meanings and actions upon findings.

The epistemological position of CGT was considered highly suitable for the current project, given that the research questions focused upon personal meanings (identity), actions (social participation), and the potentially strong influence of wider social contexts (e.g. ageism). However, it was not possible to conduct some important facets of CGT methodology within the constraints of the Doctorate in Clinical Psychology training programme (e.g. simultaneous data collection and analysis, delayed literature review, purposive sampling). Instead, Thematic Analysis (TA; Braun & Clarke, 2006) was adopted, not only because it was more feasible to conduct, but also because it is not tied to any particular theory of knowledge and therefore allowed for incorporation of CGT epistemology.

The following steps were followed in conducting the analysis:

1. Transcription of data

The author transcribed all but two interviews verbatim; the remaining two were transcribed verbatim by an undergraduate student who wanted to gain some research experience.

2. Importation of data into *Dedoose*

For ease of data management, all transcripts were imported into the software package *Dedoose* (Dedoose, 2013).

3. Familiarisation with data

In order to immerse herself in the data set, the author read all interviews once before beginning the analysis proper.

4. Coding

During coding, the author worked systematically through all the transcripts one by one, trying to give full and equal attention to each data item. She attempted to identify all data items that held relevance to the research questions, and coded such items by “tagging” them in Dedoose. Following CGT principles (Charmaz, 2006), the author attempted to code *meanings* and *actions*, and to take an inductive approach such that codes were generated directly from the data (rather than from any pre-existing theory or personal assumption); thus, interpretation was kept to a minimum at this stage.

5. Code checking

Another researcher (KS) independently coded two transcripts using the same procedure outlined above. This procedure confirmed the codes identified by the author, but additionally introduced some novel codes which were then incorporated into the analysis.

6. Collating codes into themes

The author and KS met to discuss how the generated codes might be interpreted and combined into broader themes. Here, following CGT principles, interpretation was explicitly employed as a tool for the elucidation of participants' meanings; thus, the researchers adopted a reflexive stance in order to maintain awareness of their personal influences upon the generated themes.

7. Reviewing and refining themes

The author met with the research team (KS, JS, GC) to discuss whether the constructed thematic structure provided a sufficiently accurate, rich, contextualised, meaningful, and useful depiction of the data set as a whole, again adopting a reflexive stance. In the few cases where themes appeared inconsistent with data, a partial re-organisation was discussed (e.g. reworking a theme, creating a new theme, collapsing two themes into one). A table listing the final themes and their constituent codes is presented in the Appendix.

## Trustworthiness

Multiple steps were taken to ensure the trustworthiness of results (Elliott, Fischer, & Rennie, 1999; Graneheim & Lundman, 2004; Malterud, 2001; Morrow, 2005). Firstly, to guard against researcher bias, a reflexive stance was adopted in which the researchers assessed the impact of their own biases and the possibility of alternative interpretations. Additionally, a team-based approach was employed so that no single perspective held undue influence. To assure credibility, portions of the analytical process were performed independently by two researchers (JG, KS) and subsequently checked for convergence, as noted above. Finally, efforts were made to present the research process transparently, in order that readers might be able to judge the value and transferability of findings: the main author wrote a *subjectivity statement* (see below) to share her personal biases (Roulston, 2010); verbatim quotes were presented to maintain participants' voices in findings; and efforts were made to contextualise the study and its participants.

### Subjectivity statement

The author's interest in older adults emerged during her 20s when she conducted clinical research into dementia. During this time, she worked with many older research participants, both with and without dementia. As she gained a strong appreciation for the rich and valuable contributions that her research participants brought (just like people of other ages), she became keenly aware of the relative invisibility of older people in contemporary society. Subsequently, her interest further developed through interactions with her maternal grandmother. In particular, the author watched her grandmother continuously refuse help as she became less able to care for herself. Over time, the author came to understand her grandmother's behaviour as an attempt to preserve her sense of independence in the context of a society that is highly disparaging of dependency. Together, these experiences led the author to develop a strong interest in ageism. In particular, she believes that widespread over-valuation of youth, economic productivity and independence leads to frequent under-valuation and denigration of older people.

Thus, her biases with regard to the current project lie in a desire to draw attention to and challenge ageism.

## Results

### Participants

Twenty-nine individuals (10 males, 19 females) living in inner-city London were referred to the study. Of the 10 referred males, five declined because they were not interested in taking part.  Of the 19 females, two could not be contacted and seven did not meet inclusion criteria. The final sample of ten females and five males ranged in age from 62 to 100 years (mean = 79, SD = 12); further sample characteristics are provided in Table 2.1. All participants lived alone, with the exception of one female who lived with her husband who had severe dementia. Whilst levels of social interaction varied, 12 of the 15 participants reported relatively restricted social networks (either *Private Restricted*, *Locally Self-Contained* or *Family Dependent*; Wenger, 1991), and all but two reported no engagement with social groups (P12 and P15 went to church weekly; Wenger, 1991, questions 7 & 8). All were classified as lonely (de Jong-Gierveld & Kamphuis, 1985). Additionally, all reported some form of illness or disability. The sample was ethnically and socioeconomically diverse.

### Themes

Analysis led to the generation of 14 themes, which were grouped into four clusters (see Table 2.2). The constituent codes for each theme, and an example of a coded excerpt, are presented in the Appendix. In what follows, themes are described and illustrated with quotes. Participants are identified by codes corresponding to Table 2.1, except where this might compromise their anonymity, and *Int.* denotes the interviewer. For ease of reading, repeated words and non-words have been deleted, superfluous segments have been replaced with an ellipsis (…), and connecting words have been inserted (enclosed in square brackets [ ] ).

**Table 2.1 Participant characteristics**

| Participant number | Age group | Gender | Network Typology | Loneliness | Depression | Ethnicity | Disability | Illness | Socioeconomic Status | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | SOC | Neighbourhood deprivation (%) |
| P1 | late | M | PR | Severe | - | White British | Mobility, vision | - | 1-Management | 5 |
| P2 | late | F | PR | Moderate | - | White British | - | Memory, history of falls | 3-Technical[1] | 15 |
| P3 | late | F | PR | Severe | Mild | White British | Mobility, vision | Bowel condition | 8-Operative | 14 |
| P4 | early | F | LSC | Moderate | Mild | Central Asian | Mobility | - | 2-Professional | 16 |
| P5 | late | M | PR | Severe | Moderate | White British | Mobility | - | 4-Administrative | 31 |
| P6 | mid | F | WCF | Very Severe | Moderate | White British | - | Chronic depression | 2-Professional[1] | 7 |
| P7 | early | F | PR | Moderate | Moderate | Black Caribbean | Mobility, vision | Diabetes | 2-Professional | 18 |
| P8 | late | F | FD | Severe | Mild | White British | Mobility | - | 1-Management[1] | 13 |
| P9 | late | F | PR | Moderate | Moderate | White British | Mobility, registered blind | - | 2-Professional | 13 |
| P10 | early | F | PR | Very Severe | Severe | White British | Mobility | History of stroke | 9-Elementary | 22 |
| P11 | late | F | PR | Moderate | Mild | White British | Mobility | History of falls | 4-Administrative | 14 |
| P12 | mid | M | LI | Severe | Severe | South-East European | Mobility | History of cancer | 5-Skilled trades | 20 |
| P13 | early | M | PR | Moderate | - | White British | Cerebral Palsy | - | 8-Operative | 19 |
| P14 | late | M | PR | Moderate | Severe | White British | Mobility | History of stroke | 9-Elementary | 33 |
| P15 | mid | F | WCF | Severe | - | Black Caribbean | Vision | Diabetes | 5-Skilled trades | 23 |

***KEY: -**, absence of depression, disability or illness; **[1]**, occupational classification based on spouse's occupation, see methods; **Age group**; "early" 60-69, "mid" 70-79 years, "late" 80+ years; **Depression**, see methods; **F**, female; **Network Typology**, see methods; **Loneliness**, see methods; **M**, male; **Memory**, subjective memory impairment; **Mobility**, age-related mobility difficulties; **Neighbourhood deprivation**, index of neighbourhood economic deprivation, see methods; **SOC**, Standard Occupational Classification, see methods; **Vision**, age-related visual impairment.*

**Table 2.2 Clusters and Themes**

| Clusters | Themes |
|---|---|
| **1. Overt barriers** | 1.1 Illness and disability<br>1.2 Loss of friends and family<br>1.3 Loss of community<br>1.4 Perceived lack of social opportunities |
| **2. Responses to barriers** | 2.1 Minimising the difficulties of loneliness<br>2.2 Not seeking social interaction<br>2.3 Avoiding social opportunities<br>2.4 Relying on the telephone<br>2.5 Keeping busy with solitary activities |
| **3. Social fears** | 3.1 Fear of rejection<br>3.2 Fear of exploitation |
| **4. Fear of losing preferred identities** | 4.1 Fear of losing “independent” identity<br>4.2 Fear of losing “youthful” identity<br>4.3 Fear of losing preferred social identity |

### Cluster 1: Overt barriers

Themes in this cluster described overt barriers to social participation that participants articulated in their interviews, including illness/disability, loss of friends and family, loss of a local community, and a perceived lack of social opportunities. Data indicated that each of these barriers consisted of an interplay between objective components (e.g. actual lack of social opportunities) and perceived components (e.g. perception of lack of social opportunities). Since these barriers align with previous literature, they will be described only briefly here.

### *1.1 Illness and disability*

Almost all participants said that their illnesses and disabilities led to a range of practical issues that made social participation challenging, including low energy levels, difficulties utilising transport, difficulties managing symptoms, and problems mobilising.

*P4 I have weakness in my legs [and] I get tired extremely soon, so from that point of view [it's] sort of difficult in trying to go out.*

In addition to these practical issues, participants explained that *anxieties* about their health/disability issues discouraged them from social participation; they worried about falling, being unable to cope with symptoms whilst not at home, and the unpredictability of accessible transport.

*P3 If you go out by [accessible taxi] … you wonder if they're gonna turn up.*

*P11 I think I'm gonna fall over at [any] moment.*

### *1.2 Loss of friends and family*

Around two thirds of participants related their low interaction levels to the absence of old friends and neighbours who had died, and the absence of family members who had moved away.

*P14 The majority of blokes I knew went to the pubs, well they're dead and buried.*

*P12 [My family] phone me up sometimes but they can't come here, they are very far.*

This lack of existing social contacts was compounded by a reluctance to form new relationships with “strangers”, who participants felt would not understand them or offer genuine support.

### *1.3 Loss of community*

Around half of the participants mourned the loss of an “old community” in which residents had supported one another. They felt abandoned by “uncaring” neighbours and therefore disinclined to pursue local social opportunities.

*P5* *If you was missing … [neighbours] would knock on the door and just find out if you was alright. You don’t get none of that today.*

*P10* *I don’t think I’d want to go [to a local group] … For four years I’ve been sitting here and you haven’t helped … You’re not nice people. I don’t want to know.*

They associated the loss of community with a high turnover of local residents (especially the influx of younger people and non-English speakers), a perceived increase in crime, and the loss of valued social groups. Notably, perceptions of a lost community were particularly prevalent among participants from lower socioeconomic backgrounds.

*P15* *This [neighbour] is Polish. That one is Turkish. Who the hell do you associate with? … I’m the only original resident on this block. Everybody has changed.*

*P10* *[Neighbourhood meetings have] finished now, because not near enough people could be bothered … There were a lot of us, but now nobody cares.*

### *1.4 Perceived lack of social opportunities*

Almost all participants had little knowledge of local social opportunities. The men in the sample were often unaware that social opportunities might exist, whilst the women tended to have a basic awareness of services but limited knowledge of specific opportunities. Additionally, most participants asserted that they would not like particular activities offered at groups (which they thought might typically include bingo, "light entertainment", and chatting), or the food provided.

*P3 Well I don't mind mixing with people but, um, I don't know what groups there are.*

*P14 Oh look, [social groups are] a load of crap and people all "yap yap yap yap" talking all the time.*

*P2 If [lunch is] put before me … [it might] just put me off. Will I hate it, their sort of food? I don't know.*

## Cluster 2: Responses to barriers to social participation

This cluster describes participants' responses to the barriers to social engagement that they encountered. Notably, most minimised their difficulties, did not seek to increase their interaction levels, avoided social opportunities, and/or gave up on socialising altogether. Instead, they coped by relying on telephone communication and solitary activities.

### *2.1 Minimising the difficulties of loneliness*

Around half of the participants asserted that they enjoyed spending time alone. However, when probed, they admitted to desiring more interaction. Additionally, in apparent attempts to demonstrate that they were coping, they inadvertently revealed the uncomfortable challenges brought by loneliness.

*P9 I just take [being alone] in my stride.*

*P4 [Being alone] doesn't bother me anymore.*

It appeared that participants were unsatisfied with their isolated lives, but tried to cope through minimising their difficulties and emphasising the positives.

*P11 Don't feel sorry for me or anything. I mean, I'm OK … It took me a long time to get used to this but I'm getting used to it now … I think, well, you've seen [the world], you have to be thankful for that … So I try to make myself feel better about it all.*

### *2.2 Not seeking social interaction*

All participants exhibited a general lack of interaction-seeking behaviour in response to their loneliness. They tended to state that they would not consider contacting anyone (individuals or services) if they were feeling lonely. They also seemed to accept aversively low levels of social contact, without asking for anything more.

*Int. Do you ever think about contacting anybody at all if you're feeling lonely?*
*P5 Well there ain't anybody much I know.*
*Int. You wouldn't think about contacting any of the people that you've told me about?*
*P5 Nah.*

*P11 [My friend] who takes me shopping had been away, so I hadn't been out for quite some time.*

Moreover, several participants indicated that they had ceased looking for suitable opportunities to socialise, given their circumstances. They communicated a sense of hopelessness and defeat, which in some cases appeared indicative of low mood more generally. At the same time however, there was no clear association between depression and isolation and/or loneliness across the sample as a whole (Table 2.1).

*P11 Well I just can't be bothered … I just don't want to make the effort. I mean, I don't get up very early in the mornings … When I feel lonely I don't want to do anything … [I've] just lost interest.*

### *2.3 Avoiding social opportunities*

Almost all interviews revealed strategies that participants used for avoiding social interaction opportunities. For example, participants stated that they would refuse any invitations to local groups without hesitation. They also described "putting off" interactions; some directly admitted this, whilst others gave incoherent reasons for missing social opportunities that were suggestive of delaying behaviours.

*P8 I made up my mind that I was going to go to this centre, but [my son] was here. I had to cook for him, look after him, so really I couldn't get to where I wanted to go. So that's the reason I didn't go, it was all to do with him …*
*Int. And when he went, did you go?*
*P8 No … then I thought … five weeks, it's passed, and no I didn't.*

Additionally, almost all participants' avoided social opportunities on the basis of negative predictions, e.g. that activities would not be enjoyable, or that others would not be welcoming.

*Int. What do you think the [group] atmosphere would be like?*
*P9 Well, I can only imagine what it would be like but I don't know from experience.*
*Int. No, what do you imagine it would be like?*
*P9 Well, I just wouldn't feel comfortable.*

### *2.4 Relying on the telephone*

Around two thirds of participants stated that talking to friends and relatives on the telephone helped them to feel less lonely. For these individuals, the telephone seemed to provide a social “lifeline” that kept them going.

*Int.* *If you’re feeling lonely do you ever think about getting in touch with anybody?*
*P15* *Well I’m always on the phone.*

### *2.5 Keeping busy with solitary activities*

All participants reported using solitary home-based activities to mitigate loneliness, particularly television-watching, radio-listening, reading/writing, and doing household chores. Three participants described solitary activities as direct replacements for face-to-face interaction, and one of them claimed that she was so busy that she rarely felt lonely (P3).

*P5* *If I’m watching football I don’t mind … I get carried away with that, so I’m alright.*

*P15* *I will watch the TV in the evenings only for just to have a bit of noise in the house and a bit of companionship.*

## Cluster 3: Social fears

Themes in this cluster suggested that participants avoided social opportunities for fear that they would be rejected and/or exploited by their peers.

### *3.1 Fear of rejection*

Around half of the participants, and particularly women, feared various forms of rejection by social groups, neighbours and services, including: being excluded from group discussions/activities (particularly by pre-existing members who might be reluctant to admit newcomers), being refused help by services, and being humiliated following transgression of perceived social standards (e.g. making "mistakes" during discussions). Those who seemed to fear rejection the most reported a longstanding (and perhaps lifelong) preoccupation with this issue.

*P11* *I've met those sort of clubs before, where people stick together and they don't want anyone new in … I don't want to go.*

*P2* *I don't like being an outsider … I don't want them not to like me … I don't want to be scorned.*

*P7* *Ask for help and you're turned down. That hurts … It's not worth the aggravation … I don't want to ask anybody for anything, nothing … I don't want another knock-back.*

### *3.2 Fear of exploitation*

Four female participants avoided social groups because they feared that members would exploit their kindness and generosity. In particular, they worried that group members whose moral standards did not match their own would "pluck their eyes out" (P15), and that vulnerable members might become burdensome.

*P6* *Obviously people have to tell me their problems … and I will get worried about them … I want to go to groups that will make me feel better, not burdened with more problems.*

## Cluster 4: Fear of losing preferred identities

Themes in this cluster suggested that most participants avoided social opportunities due to fears that attendance would threaten valued or preferred aspects of their identities. In particular, they feared losing their “independent” and “youthful” identities, and their preferred social identities.

### *4.1 Fear of losing “independent” identity*

Almost all participants emphasised independence (being capable of supporting themselves) as a valued and honourable aspect of their identities. At the same time, they equated help-seeking with dependency, incapability, and additionally amorality, because in their eyes it involved exploiting the kindness of others. Importantly, participants saw accessing community services as a form of help-seeking that would threaten their independent identities. For example, one man who struggled to look after himself avoided a lunch group for fear of losing his self-sufficiency (P12). However, six participants expressed a desire to support others, and two said that they would happily receive support if they could simultaneously support the other person. Therefore, engagement in reciprocal helping roles appeared acceptable, whilst dependency was not.

*P7 I’m not asking for help. I’ll [go to a group] if I feel I can bring something.*

### *4.2 Fear of losing “youthful” identity*

Around two thirds of participants characterised “old” people in very negative terms, describing them as sick, disabled, dependent, incapable and decrepit. Thus, it was unsurprising that participants made frequent attempts to distance themselves from "old" people, often describing themselves as youthful and "young at heart".

*P8* *I don't really act like an old person … I'm very young at heart … When I get dressed up, I don't think I look like some of them … But I feel sorry for old people.*

Furthermore, participants imagined that groups for older people consisted of rooms of "lifeless" individuals doing nothing and waiting to die. Thus, they avoided such groups, believing that they would have nothing in common with members, and fearing that attendance might make them "old" too.

*P12* *I see all [these men] sleeping like that, sleeping. They all have their mouth open … No, I don't wanna be like that. I don't wanna go and sit in [that group] … No.*

*P7* *If you go in a group and they're all older … you become like them too.*

Instead, participants expressed preferences to associate with youthful people who might help them to feel "young again", but struggled to find such opportunities.

Notably, an opposite process was observed in interviews with three male participants, all aged 80 years or above: they explained that they had withdrawn from social opportunities because they viewed themselves as "too old" (P1, P5, P14).

### *4.3 Fear of losing preferred social identity*

Almost all participants wished to avoid social opportunities that might contradict their preferred social identities (see Table 2.3). For example: a woman who described herself as socially refined avoided mixing with anyone she perceived as "common"; another woman who described herself as educated avoided a group with members she perceived as "not bright"; a man whose identity as a sports fan involved taking part in repartee eschewed mixing with people who did not offer "jolly" conversation; a Christian woman who described herself as selfless had withdrawn from church activities because she viewed other worshippers as "greedy"; a man who described himself as a "normal guy with a disability" (cerebral palsy) evaded groups in case others treated him as "different". Instead, participants desired, but struggled to find, social opportunities that reinforced their preferred social identities. For example: participants who regarded themselves as educated desired opportunities for intellectual discussion with similarly educated others; a woman who saw herself as a caregiver wished to interact by continuing her charity work; an ex Church minister wanted to engage in church-based activities; a retired doctor wanted to socialise with other doctors.

*P4* *As a professional I would rather be in [a] group of professionals, because you learn a lot from them, even by talking afterwards … otherwise … you're sort of restricted in the character and attitude of some of people.*

*I* *What would [your ideal group] look like?*
*P9* *… A local church fellowship group …*
*I* *And the other people, what would they be like?*
*P9* *Well, I would imagine … they would be of similar persuasion as myself.*

Notably, these processes seemed to operate regardless of social identity (Table 2.3), ethnicity or socioeconomic status. Overall, data suggest that social participation may reduce when interaction opportunities seem to contradict preferred identities, as P15 surmised:

*P15* *I'm not gonna be naïve enough to think that if I join any group … that everybody's gonna be like me. I just have to learn to fit in, and if I can't then I don't go.*

**Table 2.3 Participant social identities**

| Social identities |
|---|
| Political/community activist, educated person |
| Wife, educated person, friend |
| Mother, friend, hobbyist |
| Doctor, caregiver, educated person |
| Husband, father, sports fan, joker |
| Wife, mother, educated person, socially refined person, charity founder, caregiver, friend |
| Professional caregiver, educated person, mother, friend |
| Wife, mother, educated person, socially refined person, friend |
| Christian, church minister, caregiver |
| Caregiver |
| Educated person, friend |
| Respectable family man (honourable, dedicated to care of family), father |
| "Normal bloke" (enjoys sport & pubs) with a disability |
| "Normal bloke" (enjoys sport & pubs) |
| Christian, church volunteer, mother, caregiver |

## Discussion

Using qualitative interview-based methods, this study sought to elucidate barriers to social participation, and responses to these barriers, in a sample of lonely older adults. Whilst reduced social participation in later life has been previously studied from various perspectives, this study was unique in its focus on lonely individuals and its attention to psychological processes including social identity. The most salient barriers articulated by participants aligned with previous research, and included illness/disability, loss of contact with friends/relatives, lack of a supportive community, and lack of acceptable social opportunities (e.g. Bowling & Stafford, 2007; Fristedt et al., 2011; Jansen, 2005; Levasseur et al., 2011; Pollack & von dem Knesebeck, 2004; Walker et al., 2012; Walker & Hiller, 2007). Somewhat counter-intuitively, but in convergence with a recent study (Schoenmakers, van Tilburg, & Fokkema, 2012), participants seemed to respond to these barriers not by seeking new and accessible social opportunities, but by psychologically minimising the challenges of loneliness, avoiding social opportunities, and attempting to cope alone. However, careful exploration of the data revealed two subtle yet powerful psychological processes that may explain participants' active avoidance of social opportunities: fear of social rejection and/or exploitation, and fear of losing preferred aspects of identity. These particular barriers to late life social participation have not been previously described, and therefore represent a novel and unique contribution to the literature. In what follows, these barriers will be considered in detail, and ways in which they might be addressed by community organisations (including formal statutory/charitable services, and informal groups) will be suggested. In addition, a separate accessible summary of findings has been produced, to ensure that current results reach community practitioners and service commissioners (see Appendix).

### Social fears

Turning first to participants' social fears, these have previously been linked to loneliness and social isolation. Indeed, such fears are central to work by Cacioppo and colleagues (e.g. Hawkley & Cacioppo, 2010), which suggests that loneliness is related to a chronic lack of perceived safety in social situations, that leads to a range of maladaptive cognitive biases and behaviours that maintain loneliness. For example, evidence suggests that lonely individuals show hyper-vigilance to negative social stimuli (Bangee, Harris, Bridges, Rotenberg, & Qualter, 2014; Cacioppo, Norris, Decety, Monteleone, & Nusbaum, 2009), remember more negative than positive social information (Duck, Pond & Leatham, 1994), and elicit behaviours in others that confirm negative social expectations (Hawkley, Preacher & Cacioppo, 2007). Together, these processes have been named the “self-reinforcing loneliness loop” (Hawkley & Cacioppo, 2010). Whilst all of the above studies involved younger adults, limited evidence indicates that similar mechanisms may operate in lonely older people (e.g. Winningham & Pike, 2007). Applied to the current findings, these insights might indicate that maladaptive cognitive and behavioural processes contribute to reduced social participation as well as loneliness in later life.

### Recommendations for addressing social fears

Given the above-described literature, present findings may suggest that barriers to social participation could be diminished through talking therapies that target cognitive and behavioural processes, such as Cognitive Behavioural Therapy (CBT; e.g. Westbrook, Kennerley & Kirk, 2011). However, for several reasons, traditional forms of CBT may not necessarily represent the best solution to problems of social participation among older people. Firstly, given the number of people affected, universal provision of individual talking therapy is unlikely to be economically viable. Secondly, current evidence indicates that, due to their social fears, older adults with low levels of participation are unlikely to engage with therapy without significant support. Thus, researchers might seek to build on preliminary efforts to design and evaluate economically viable group-based CBT interventions specifically adapted for older adults who show reduced social participation (e.g. Winningham & Pike, 2007). An alternative and perhaps more practical and effective solution might consist of the incorporation of CBT principles into the design of pre-existing community groups for older adults. For example, organisations might challenge fearful beliefs about attendance using the following strategies: emphasising the friendliness and inclusiveness of groups (both through discussion and the use of marketing materials); implementing a “buddy” system so that current members can inform prospective members about their experiences; and normalising social fears so that individuals realise that they are not the “only ones”. Additionally, organisations might facilitate behavioural change through encouraging potential members to take gradual, manageable steps towards social participation (e.g. first meeting with one person, then with a small group, then with a larger group); and encouraging them to “test out” their negative predictions by trying a group without any commitment to attend again. Community groups might implement such recommendations in consultation with a mental health professional such as a clinical psychologist. Importantly, future research will be required to develop and evaluate such interventions, in order to provide an evidence base upon which services can draw.

### Identity processes

The present findings suggest that lonely older adults avoid social opportunities for fear of compromising the self-conceptualisations or *identities* that they value. Firstly, in line with previous evidence, findings indicated that participants were highly motivated to uphold independent and youthful identities (Andersson & Oberg, 2006; Coleman, Ivani-Chalian, & Robinson, 1998; Grant, 2006; Hochschild, 1973; Hurd, 1999; Lund & Engelsrud, 2008; Motenko & Greenberg, 1995; Oberg & Tornstam, 2001; Rudman, 2006). This was evident in their frequent attempts to emphasise their self-sufficiency and to distinguish themselves from “old” people, who they described as dependent and decrepit. Moreover, they appeared to avoid opportunities for social support, especially those associated with older people, for fear that engagement would invalidate their independent, youthful identities and instead mark them as old and dependent. Secondly, participants were keen to emphasise and maintain their pre-existing and preferred *social identities* (self-conceptualisations derived from group memberships, e.g. caregiver, Christian, educated person, sports fan, "bloke"). Thus, in alignment with previous studies of social identity (e.g. Jetten et al., 2012; St Claire & He, 2009), they avoided social situations that might contradict these identities, and wished for (but struggled to find) opportunities that might instead provide identity-reinforcement.

### The influence of ageism upon identity processes

These identity processes described here must be considered within the broader context of a society that is often described as ageist (e.g. Age UK, 2013; Angus & Reeve, 2006; Bytheway, 1995; Dillaway & Byrnes, 2009; Fealy, McNamara, Treacy, & Lyons, 2011; Hagestad & Uhlenberg, 2006; Hagestad & Uhlenberg, 2005; Nelson, 2002, 2005; Nussbaum et al., 2005; Palmore et al., 2005; Phillipson & Biggs, 1998). In particular, societal discourses commonly invoke a dichotomy between young and old, in which youthfulness is associated with valued traits such as independence, economic productivity and usefulness, whilst ageing is associated with characteristics deemed intensely negative, like dependency and uselessness (e.g. Fealy et al., 2011; Kite & Johnson, 1988; Phillipson & Biggs, 1998). Thus, participants' efforts to maintain youthfulness and independence can be reframed as attempts to preserve valued identities in a societal context that threatens to denigrate and exclude on the basis of age alone. Additionally, participants' efforts to maintain pre-existing social identities, which were often associated with being productive or useful in some way, might also form part of this process. Strikingly, the fact that most current participants seemed to seek to maintain preferred identities at the cost of almost complete social isolation may attest to the power of these identity processes.

### Recommendations for addressing identity processes

Through taking note of identity processes and facilitating the pursuit of socially valued identities, community groups might succeed in engaging more lonely older adults; indeed, there is preliminary empirical support for this approach (Heaven et al., 2013). Firstly, organisations could develop opportunities that reinforce older peoples' preferred social identities and therefore encourage participation. Secondly, organisations might seek to reinforce "independent" identities by enabling older people to design, organise and deliver their own social opportunities. Notably, these two approaches combine particularly well: if older people take ownership of groups and activities, it can be suggested that resultant social opportunities will better reflect their preferred identities. Such ideas are exemplified by the *Men's Sheds* movement, in which older men take ownership of activities that are perceived to support their male identities, such as woodwork, gardening and engineering (http://www.menssheds.org.uk; Ormsby, Stanley & Jaworski, 2010). Thirdly, "independent" identities might also be supported through the provision of educational and volunteering opportunities that allow older adults to build productive and thus socially valued roles (Greenfield & Marks, 2004). Fourthly, organisations might develop social opportunities that de-emphasise age and thus avoid contradicting "youthful" identities. Specific strategies might include schemes that enable older adults to work with younger people (*Trans-age Action*; Kessler & Staudinger, 2007), or neighbourhood-based social events open to all ages. In efforts to develop these ideas, it will be of paramount importance that community organisations conduct research to evaluate outcomes and build an evidence base upon which others may draw.

Whilst the adoption of these ideas might increase social participation among some lonely older adults, certain subgroups are less likely to benefit. For example, evidence suggests that older people with the least resources (health, social, financial), who might conceivably benefit the most from volunteering opportunities, are the least able to participate (Martinson & Halpern, 2011; Martinson & Minkler, 2006; Minkler & Holstein, 2008; Thoits & Hewitt, 2001). Furthermore, by promoting independence, productivity and youthfulness as normative ideals, community groups risk inadvertently reinforcing ageist views and devaluing older people who cannot embody these characteristics (Martinson & Halpern, 2011; Martinson & Minkler, 2006; Minkler & Holstein, 2008). Therefore, organisations (and society more broadly) might consider promoting alternative identities that are not bound to productivity, and which instead focus upon other capacities such as spirituality, emotional growth, artistic creativity, and the development of relationships (Martinson & Halpern, 2011). In particular, social opportunities that promote meaningful relationships might help older adults to build valued identities based on interconnection and interdependency instead of independence (Breheny & Stephens, 2009; Fine & Glendinning, 2005; Lloyd, Calnan, Cameron, Seymour, & Smith, 2014; Tanner, 2001). Moreover, the adoption of relationship-based identities might allow support-seeking to be viewed as an identity-congruent process that serves to maintain connectedness to others; and this might enable older people to accept and benefit from social support. Notably, the acceptance of reciprocity shown by participants in the current study indicates that they would be receptive to such an approach. Perhaps most importantly, by relieving people of the impossible expectation of staying forever youthful and productive, and providing alternative means to construct a positive identity, community groups might increase their levels of engagement with older people whilst simultaneously making meaningful contributions to the fight against ageism in wider society. Clearly, much future research is required to build an evidence base that indicates how to best support positive ageing identities. However, work might include an examination of already extant ageing identities, as well as the careful evaluation of intervention outcomes.

## Limitations

Whilst the current study sought to examine processes of reduced social participation in lonely older people, it did not provide direct evidence for links between participation and loneliness. However, results highlight the plausibility of such links, and indicate that their investigation should become a priority for future research.

It is probable that the current results were somewhat biased by commonplace difficulties in recruiting lonely older people to research (e.g. Dickens et al., 2011; Ollonqvist et al., 2008; Saito et al., 2012). Here, it is conceivable that the loneliest individuals were less likely to be referred to the study due to a lack of contact with services. Additionally, the loneliest people referred may have been least likely to agree to participate. This latter problem seemed particularly true among the referred men, 50% of whom said that they were not interested in taking part (compared to 0% of referred females). Nevertheless, all participants were classified as lonely, and over half surpassed the criterion for “severe loneliness” (de Jong-Gierveld & Kamphuis, 1985). Additionally, a satisfactory gender mix was obtained (5 males, 10 females). Therefore, whilst the loneliest subgroup of older adults may not have been represented here, and men may have been under-represented, conclusions were nevertheless based on a significantly lonely sample. However, these limitations highlight a need for work that directly examines barriers to research participation in this population, in order to facilitate future progress in this field more generally.

It is surprising that the present results did not indicate any particular influence of ethnicity or culture, given the multi-cultural context in which the research took place. In part, this may be due to the under-representation of people from non-White British backgrounds: whilst these people account for approximately 55% of London's population (Office for National Statistics, 2012), they only constituted 25% of the current sample. This under-representation of non-White British identities seemed to reflect the referral rather than the recruitment process: of the 29 individuals referred, only 6 identified with non-White British ethnicities, and whilst all these individuals were willing to take part, only 4 met inclusion criteria. This evidence may suggest that older people from ethnic minority backgrounds were less likely to be known to the referral agencies involved in this study. Furthermore, in line with other findings (Barnes et al., 2004; Campbell & McClean, 2002; Lindström, 2005; Scharf, Phillipson & Smith, 2005; Victor, Burholt & Martin, 2012), such observations might tentatively indicate reduced social participation and increased loneliness among this population more generally. However, these associations are likely to vary between particular ethnic groups (e.g. Victor, Burholt & Martin, 2012) and may be mitigated by high levels of within-group participation (e.g. Campbell & McClean, 2002). Thus, cross-cultural differences in barriers to social participation are probable, and future research is required to explore this issue.

When considering the application of the present results, it is important to bear in mind that they represent the interaction of a particular research team with a particular group of participants in a particular context. However, the use of reflexivity, credibility checks and a transparent approach increased the trustworthiness of findings, and allowed readers to make their own judgements of the study. Additionally, the relative social, economic and cultural diversity of the sample suggests that the findings are not tied to any particular sub-population. Thus, present findings might be related to other lonely older adult populations with caution.

## Conclusions

The findings of this study illuminate barriers to social participation among lonely older adults, including both commonly cited and novel factors. The novel factors, which represent a unique contribution to the literature, suggest that reductions in late life social participation may reflect commonplace fears of social rejection/exploitation, and fears of losing preferred aspects of identity. Taken together, present results suggest that social participation amongst lonely older people may not be improved by removing commonly reported barriers alone; instead, it may be necessary to address individuals' beliefs, fears, values and identities.

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# Part 3: Critical Appraisal

This critical appraisal comprises an exploration of the main issues that preoccupied me whilst conducting this research. Firstly, I will discuss the way in which my own assumptions affected the research process, and how I attempted to manage this through a process of reflexivity. Next, I will describe some of my personal experiences of the interviewing process, and in particular, how I managed some of my emotional responses. Subsequently, I will suggest ideas for future research that might follow on from this project. Finally, I will discuss the impact of the present work on practice, particularly with reference to the agencies that took part in this project.

## 1. The influence of personal assumptions and the process of reflexivity

I came to this project with a range of assumptions that may have influenced outcomes at multiple levels, from the initial choice of topic and the design of the research methods to the conduction of interviews and the generation of themes. However, this is by no means a new or unique problem; indeed, it is commonly acknowledged that all researchers carry assumptions that reflect their experiences, values and beliefs, and which inevitably influence their work (e.g. Willig, 2013). Given that personal assumptions cannot be eliminated, it is my view that the value of research is increased when they are explicitly acknowledged. Additionally, I believe that the consideration and presentation of a researcher's influence upon outcomes, known as the process of *reflexivity* (e.g. Willig, 2013), generates richer findings that readers can more easily assess in relation to their own settings. Moreover, I think that as researchers become increasingly reflexive and aware of their own perspectives, they become more receptive to novel perspectives, such that results are less bound by prior assumptions. In reflection of these views, I saw this work as the co-construction of the participants *and myself*, and explicitly adopted a social constructionist perspective to help me explore my personal impact upon the work (Constructivist Grounded Theory, CGT; Charmaz, 2006). Through transparency with regard to my assumptions (see my *Subjectivity Statement* in Part 2), and attempts to maintain reflexivity and receptivity to novel perspectives throughout, I hope that I produced a richly contextualised account of problems of social participation in later life, which might be useful in the future development of practice. However, I am aware that a different researcher with a different set of assumptions might have produced a different, but equally useful, set of findings. In what follows, I would therefore like to consider how current results were influenced by my presence in this work, and how they might have been different.

### 1.1 My assumptions

The first of several assumptions that I brought to this research was a view that social participation is an entirely good thing, both for individuals and for wider society. I think that this view emerged from a range of experiences: my training as a clinical psychologist in which social activities and relationships are typically viewed as fundamental aspects of psychological wellbeing; my own positive experiences of social participation; my exposure to the apparently negative effects of social withdrawal upon my maternal grandmother (see *Subjectivity Statement*, Part 2); and perhaps a personal ethical stance that favours the development of inclusive, supportive communities in which no one is forgotten.

Secondly, I carried with me a political stance that is strongly opposed to ageism. As set out in my Subjectivity Statement (Part 2 of this thesis), I gradually developed this perspective through witnessing the effects of ageism during clinical work with people with dementia and their families, and through interactions with my own maternal grandmother. In particular, I have often been saddened by the way in which prevalent ageist attitudes become internalised such that older people sometimes adopt a negative view of themselves that can be self-limiting. I think that this position, charged by emotive personal experiences, meant that I was primed to see participants struggling against age-related stigma, stereotypes and systemic segregation, and may have left me less able to recognise their coping mechanisms and strengths.

### 1.2 Challenges to my assumptions

Throughout the interviewing process, participants challenged my assumptions in multiple ways. Firstly, my belief that social participation is inherently beneficial and preferable to spending time alone was directly challenged when several participants asserted opposing views. For example, almost all participants described a range of solitary pursuits that they used to keep occupied and active, and which appeared to help them maintain their wellbeing at home alone.

*"I do all me own housework … If I don't do that I'm looking at the telly or I'm writing. Even when I'm looking at the telly, I'll be writing something down, you know, so I don't very often get lonely, cos I've always got something to do."*

Additionally, some emphasised the genuine contentment they experienced whilst alone. One woman greatly appreciated having time to read without interruption, and another said that it was only when alone that she felt she could “breathe”.

*“I don’t mind being on my own either. In fact I like to have time on my own.”*

Furthermore, some participants expressed beliefs, based on past experiences, that social participation could make them feel worse rather than better.

*“But I honestly feel that in getting that support … people have to tell me their problems and … I will get worried about them … I want to go to groups that will make me feel better, not burdened with more problems.”*

Secondly, my pre-formed narratives of lonely older people struggling to survive alone were challenged by participants’ descriptions of the strategies they used to maintain independence and self-sufficiency. For example, one woman who suffered mobility impairments following a stroke repeatedly described herself as a “fighter”; in particular, she explained that she maintained her upper body strength by exercising with weights, which allowed her to move around on crutches, do her own grocery shopping and generally retain her independence. Another participant described how he maintained his independence despite significant chronic health difficulties:

*“I do my own cooking, you see. I like to do my own cooking. I just manage. If I get tired I just switch off the gas and I sit down to have a rest.”*

Thus, although quantitative data suggested that most participants experienced loneliness and low mood, there was no doubt that they showed considerable strengths and coped admirably.

### 1.3 Responding to challenges to my assumptions

These perspectives introduced a dilemma for me: should I accept them at face value, or should I attempt to interpret them in light of broader evidence and other perspectives? As is normally helpful in such circumstances, I tried to adopt an intermediate response. Thus, on the one hand, I allowed my beliefs to shift; specifically, I began to realise that social participation is not always helpful, and that lonely older people have many strengths and resources that enable them to cope and even thrive alone. However, on the other hand, I remained sceptical about participants' statements and sought to question them further. I interrogated the interview data and found evidence that reduced social participation was often not a free choice, but was instead driven by fears of rejection, exploitation, and identity losses. Whilst some of these factors were expected and could be related to ageism (e.g. fear of identity loss), others were unrelated to any prior hypotheses, and therefore drew me to further open my mind to alternate theories (e.g. fear of rejection). When it came to writing up my results, although I acknowledged participant strengths and coping mechanisms (e.g. their use of telephone communication and solitary activities), I chose to foreground the barriers to social participation that I had detected, since I felt that these were the most important results to publicise.

### 1.4 How results might have been different

How might my results have been different if I had come to this research from a different perspective? Perhaps most importantly, without my interest in ageism, I don't think that this study would have been conducted, and I certainly do not think I would have focused on barriers to participation (as opposed to, for example, facilitators*).* This suggests that, whilst researchers must be careful, some degree of bias is required in order to conceive a piece of work. Additionally, I think that if I had been less interested in exploring the effects of ageism, I might have spent more time asking participants about the ways that they achieved and maintained wellbeing whilst alone. Similarly, I may have been more inclined to view participants' desires to maintain independence and youthfulness as positive coping mechanisms, rather than barriers to interaction, and this might have led me to ask different questions and derive different data. However, had I followed these lines of exploration, I probably would have missed the particular results that I ended up presenting. Furthermore, given that very little work draws links between problems of reduced late life social participation and ageism, I would argue that it is helpful to foreground the perspectives I have raised here. Whilst my influence upon this work was thus apparent, I hope that my transparency made this clear to others, and my attempts to adopt a reflexive and receptive stance kept me open to seeing other possibilities in the data. At the same time, I believe in polyphony, and hope that this research will be read alongside other work that highlights different perspectives.

## 2. Personal reflections on the interview process

This was my first experience of conducting qualitative interviews, and it certainly brought challenges. At times, both the content and process of conducting in-depth interviews with very lonely older people led me to develop strong emotional responses, including feelings of anxiety, hopelessness and anger. In this section, I will explore the origins of these feelings, the ways in which they influenced the interview process, and my attempts to manage them.

### 2.1 Managing distress and anger in the interview process

At times, I found the interviewing process distressing, and I suspect that this reaction compromised my abilities to remain reflexive and receptive, at least temporarily. When I started the study, I was conscious, at an intellectual level, of the problems posed by late life loneliness and isolation. However, as I visited more participants, I developed an experiential and more emotive appreciation for the distress, frustration and sheer emptiness that these problems can cause. Gradually, I became very aware that I was meeting with people who are almost completely hidden from society. I developed a strong and emotionally laden image of the thousands of lonely older people who must be hidden behind the closed doors of London's residential streets, and whom the rest of us unknowingly walk past without a thought, day after day. From my strong anti-ageist perspective, I could not help but feel angered by a society in which, seemingly, older people are forgotten, abandoned and neglected. These feelings coalesced when I visited one participant whose life could be seen as a microcosm of this situation. He lived alone in an extremely bare council flat, sat on a hard wooden chair watching television all day, and told me that he hadn't been outside for two years and was simply waiting to die. Additionally, throughout his interview he repeatedly and forcefully expressed vitriolic criticism of those who held power in society, particularly Conservative Party politicians and “upper class” people. Overall, the message he gave was that he felt completely disenfranchised, neglected and discarded by society.

*“You know these toffee-nosed bastards …. [They] talk down at you … Really rich you know, bags of money, filthy rich … They detest, they hate the working people, they can’t stand the sight of them … [People] don’t give two monkeys about me and my nobody. They worry about theirselves. I mean it’s a government and all them people, they worry about themselves. Rich money, rich rich people … [The council are] just waiting for me to die, they want the flat, that’s all they worry about, their flat.”*

After this particular interview, I realised that I was not only feeling angry with, but also rather depressed and hopeless about, the state of our society. Additionally, despite the fact that I knew I had access to support in the form of supervisors and friends, I felt alone in these experiences. These feelings lingered in the back of my awareness for several days (whilst I got on with other work) before I realised I was in real danger of losing my capacities for reflexivity and receptivity, and decided to seek supervision. Supervision helped me to consider the psychodynamics of the interview process, and I realised that I had partially taken on my participant’s feelings of anger, hopelessness and isolation, through a process of transference. Additionally, I realised that various personal circumstances in my life at the time of the interview meant that I was particularly ready to adopt these feelings. I also considered that this transference process might be particularly powerful since I was probably the only person who had attempted to meaningfully engage with this particular participant for a long time. The recognition of the origin of my responses allowed me to reconnect with other equally valid perspectives upon my interviews, and in particular those that recognised my interviewees’ strengths, resiliencies, and capacities for choice, autonomy and self-determination. Thus, I was able to regain a more balanced and less emotional perspective, and to an extent, maintain my reflexivity and receptivity.

### 2.1 Managing anxiety in the interview process

I think that a key challenge for me was maintaining a reflexive and receptive stance throughout, despite a sense of needing to conduct “successful” research for the fulfilment of my doctoral qualification. Whilst some motivation to succeed is obviously necessary, one also needs a certain non-striving acceptance of whatever arises, in order to remain responsive to the inevitable ups and downs of the research process. I sometimes found this balance hard to achieve and allowed my somewhat counterproductive drive for “success” to dominate. This left me with anxious feelings that increased my desires to hold onto prior assumptions, impaired my ability to reflect on my personal impact on the research process (despite an increased need for this), and reduced my receptivity to new ideas. Occasionally, I think that this manifested as a greater tendency to direct conversations towards my pre-formed assumptions, and away from other ideas. This is a process that I have often encountered in my clinical work, and which I seek to raise my awareness of through discussion with supervisors and self-reflection, as well as personal practice of meditation and yoga. Thus, I tried to transpose these clinical strategies to the research context, and believe that I was able, for the most part, to maintain a broadly reflexive and receptive stance. However, this is almost certainly an ongoing process that I will continue to work on throughout my career.

## 3. Implications for future work

Clearly much more work is required to both understand and tackle problems of reduced social participation, and loneliness, among older adult populations. In what follows, I will make some suggestions for how such work might proceed.

### 3.1 Participatory action research

I would like to suggest that a participatory action research (PAR) approach (Reason & Bradbury, 2008; also see Kagan et al., 2011) could play a key role in addressing problems of late life social participation and loneliness. As the name suggests, PAR is based on principles of participation and action. PAR is participatory because it is conducted by community-based teams formed of professionals *and* local residents who become equal partners or co-researchers; this means that work is *done with* rather than *for* people. PAR is action-focused because it seeks to progressively build, evaluate and refine practical solutions to community problems, with active participation from as many co-researchers as possible at all stages.

My reasons for suggesting PAR here are as follows. Firstly, in my view, problems of late life social participation and loneliness need to be solved with some urgency, not just understood; thus an approach involving *action* seems key. Secondly, difficulties experienced by researchers in recruiting lonely older adults to studies impose huge limitations on the development of knowledge and practice. Extrapolating from the current findings, this predicament might reflect views held by lonely older people that research participation opportunities are not personally relevant (e.g. they do not align with preferred identities), or worse, are personally threatening (e.g. they contradict preferred identities, or activate fears of rejection). Thus, in order to engage lonely older people in research (and community groups more generally), it seems key to involve them in the design and set-up of their own engagement opportunities, as suggested by PAR. Thirdly, a PAR study would be able to develop and refine methods of engaging participants over time, in response to continuous and context-sensitive feedback, and this process might allow the development of strategies that would not otherwise emerge. Fourthly, my experience of working with community agencies for the current study taught me that they possess extensive community knowledge and links that should be regarded as indispensable to research. Thus, I believe that their full involvement in research efforts, as could be facilitated within a PAR approach, is key. Finally, a PAR study seeking to investigate ways to involve lonely older people in research would likely be able to address more general questions about social participation; thus, issues of research and practice could be addressed simultaneously.

Through my recent involvement with community agencies, I have become aware of projects that embody some of the characteristics of PAR. However, it is my impression that, usually, progress is not rigorously monitored and results are not disseminated beyond the commissioning organisations. Thus, I believe that collaborations between academic researchers and community projects might prove mutually beneficial: community teams could be supported to produce rigorous, publishable studies that might be used to support funding applications and service development, whilst researchers would gain opportunities to conduct ecologically valid and practice-relevant research that actively tackles (rather than just seeks to understand) problems of social participation and loneliness. My experiences during this research project suggested that certain types of community organisations were more able to collaborate in this type of work than others. Larger charitable organisations (e.g. Age UK) were the most receptive to my study, possibly because they were relatively well-resourced, had large numbers of clients including those that were more isolated, and were more likely to be actively engaged in service/policy development work that recognises the importance of research. On the other hand, whilst I approached a number of smaller charitable organisations, and one large statutory council-run ‘Meals on Wheels’ service, these seemed less able to participate; whilst they often gave initially enthusiastic responses, they appeared ill-equipped either due to a lack human resources, or limited experience and/or understanding of the importance of research. However, even with high levels of motivation among academics and community practitioners, the success of PAR work typically depends upon the investment of significant time and effort to develop strong inter-agency and community relationships, often over the course of years. Such work was beyond the limits of what was possible within my doctoral training; however, I would be motivated to explore similar opportunities and possibilities in the future.

### 3.2 Future work beyond clinical psychology

Through this project, I have developed a view that the problems of reduced social participation and loneliness in later life extend well beyond the traditional boundaries of clinical psychology into, for example, social psychology, sociology, economics, and politics. Thus, my belief is that real progress will probably emerge only from multi-disciplinary work that targets community and societal systems as well as individuals. In particular, I think that any work to improve the wellbeing of older individuals probably depends upon the reduction of ageism in both local communities and wider society. At the community level, such work might include interventions based on principles of social psychology, which seek to reduce age-related stereotyping via encouraging meaningful interaction between people of all ages (Allport, 1954; Pettigrew, 1998; Hagestad & Uhlenberg, 2005; Hagestad & Uhlenberg, 2006). On a societal level, work might include national publicity campaigns to tackle ageist views, similar to those used in recent years to reduce discrimination against people with disabilities. Additionally, work is needed to increase the positive representation of ageing in the media, and to decrease the acceptance of negative stereotypes. As outlined in Part 2, I also believe that any work to influence societal perceptions of older people should not simply emphasise the maintenance of youthful independence and productivity, since this is unrealistic for many, but should instead seek to encourage the valuation of a broader range of qualities and pursuits, perhaps including spirituality, artistic creativity, emotional growth and relationships (Martinson & Halpern, 2011). I think it likely that progress will also depend upon the continuation of governmental work to support the inclusion of all irrespective of age, for example, with regard to involvement in work and volunteering (e.g. The Equality Act 2010; Department for Work and Pensions, 2013); such laws and policies not only actively tackle discrimination, but also send an anti-ageism message that may gradually filter through to the public. Finally, given a wide body of health inequality literature that describes links between financial disadvantage and poor wellbeing (e.g. Marmot, 2002), efforts to address problems of late life social participation and loneliness are likely to depend upon future governmental action on economic matters that affect older people, including pension reform, fuel poverty, and social housing (e.g. Department for Work and Pensions, 2013b; Department of Energy and Climate Change, 2013; Department for Communities and Local Government, 2011). Clearly the range of large-scale work briefly described here is neither a quick fix, nor is guaranteed to help. However, there seems to be more energy directed to the improvement of older people's wellbeing than ever before, in large part due to the campaigning activities of non-statutory organizations including Age UK and The Campaign to End Loneliness, and this gives me hope for the future.

## 4. The impact of the current study

The current findings have already been disseminated to participating community organisations, in the form of an accessible summary (see Appendix). Additionally, I recently met with the Chief Executive Officer of the Age UK organisation most closely involved in this project, to discuss the implications of the study. His feedback was very positive: he told me that the findings were “reverberating around his organisation”, and helping staff to develop new perspectives on their work with isolated older people. He was particularly struck by the idea that social fears (fear of rejection and/or exploitation) may play a role in reduced social participation, since his organisation had not considered this previously. He said that he was keen to explore how psychological approaches might help to overcome this barrier at a practical level, perhaps through consultation with clinical psychologists. Whilst he was already familiar with older people’s preferences for groups and activities that do not emphasise age, and which instead focus upon preferred activities and identities, his view was that the present research would support his organisation’s efforts to “sell” such ideas to commissioners. As a next step, he suggested that we organise a meeting with all the agencies involved in the research, and local service commissioners, in order to further discuss the ways in which the present results might influence future practice. At the point of writing, we are in the process of organising this meeting, and several other community service managers and practitioners have expressed interest in attending. I have been very encouraged by the positive and interested responses to this work so far, and hope to continue disseminating findings through both meetings, presentations and publications, so that they may make a helpful contribution to practice.

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# Appendix

## Interview schedule

**a) Introduction**

- Thanks for agreeing to take part.
- Interview focus recap. I will ask you about (1) how you describe yourself, and (2) your views and experiences of local groups and services.
- Timing recap. The interview will last 1 - 1 ½ hours. Please feel free to ask for breaks and/or multiple shorter interviews if required.
- Confidentiality recap. Your information will be unrecognisable, well-protected, and anonymous.
- Recording recap. I will use audio recording to enable transcribing. All recognisable info will be removed. After transcription, your recording will be deleted.
- Any questions?

**b) Identity**

*Aim: to gain a sense of participant's valued social identities, and associated personal meanings.*

**Main Question 1:** How would you describe yourself?

**Sub-questions** (use flexibly to help fulfil the stated aim of main question)

- What kind of person are you?
- How would you describe yourself to a person who didn't know you?
- How would other people describe you?
- What groups have you belonged to?
- What roles have you played in life?
- What are your most important characteristics?
- What does being a [valued identity] say about you as a person?
- What does it mean to you that you are/were [valued identity]?
- If I didn't know you, but I knew you are/were [valued identity], what would that tell me about you?

**c) Social participation**

*Aim: to gain a sense of participants' beliefs and behaviours in relation to social participation opportunities (particularly groups), and how these are influenced by their valued identities (as ascertained in part B), as well as other factors.*

**Main Question 2:** If someone invited you to join a group (or other service), what would you do?

**Sub-questions** (use flexibly to help fulfil the stated aim of main question)

- What would you think? What would go through your mind?
- Why would you do (or not do) that?
- What gets in the way of you going to a group/accepting a service?
- What do you think it would be like if you went to a group/accepted a service?
- What's the worst thing that might happen if you went to a group/accepted a service?
- What would it say about you as person if you went to a group/accepted a service?
- Is this related to being a [valued identity from part B]?

**Main Question 3:** If you could wave a magic wand, and create your perfect group (or other service), what would it be like?

**Sub-questions** (use flexibly to help fulfil the stated aim of main question)

- What kind of people would be there?
- What would you do?
- What makes this particularly appealing for you?
- Is this related to being a [valued identity from part B]?

**d) Loneliness**

*Aim: to gain a subjective sense of how the participant typically responds to loneliness.*

**Main Question 4:** Lots of people feel lonely from time to time. If you felt lonely, what would you do?

**Sub-questions** (use flexibly to help fulfil the stated aim of main question)

- Would you contact anyone?
- Would you think about contacting any local services or groups?
- Why would you do (or not do) that?
- What gets in the way of contacting [person/service]?
- What would it say about you as person if you contacted [person/service]?
- Is this related to being a [valued identity from part B]?

**e) Demographic information**

What is your age?
How would you describe your ethnicity?
Do you suffer from any illnesses?
Do you have any disabilities?
What is/was your occupation? Can you describe your role?

**f) Quantitative Measures**

*Measures (see below) are administered with support from the interviewer as required.*

**g) Debriefing**

- How did you find the interview?
- Do you have any questions about any of the things we talked about?
- Was there anything we said that has left you feeling concerned or unsettled in any way?
- Would you like more information about anything that we talked about?
- Do you have any questions about the research project or what will happen to your information?

## Quantitative measures

N.B. Measures were presented as shown but in larger type (size point 16)

a) de Jong-Gierveld Loneliness Scale (de Jong-Gierveld & Kamphuis, 1985)

| | | | |
|---|---|---|---|
| There is always someone I can talk to about my day-to-day problems | Yes | More or less | No |
| I miss having a really close friend | Yes | More or less | No |
| I experience a general sense of emptiness | Yes | More or less | No |
| There are plenty of people I can rely on when I have problems | Yes | More or less | No |
| I miss the pleasure of the company of others | Yes | More or less | No |
| I find my circle of friends and acquaintances too limited | Yes | More or less | No |
| There are many people I can trust completely | Yes | More or less | No |
| There are enough people I feel close to | Yes | More or less | No |
| I miss having people around | Yes | More or less | No |
| I often feel rejected | Yes | More or less | No |
| I can call on my friends whenever I need them | Yes | More or less | No |

b) Geriatric Depression Scale (GDS-15, Sheikh & Yesavage, 1986)

| | | |
|---|---|---|
| Are you basically satisfied with your life? | Yes | No |
| Have you dropped many of your activities and interests? | Yes | No |
| Do you feel that your life is empty? | Yes | No |
| Do you often get bored? | Yes | No |
| Are you in good spirits most of the time? | Yes | No |
| Are you afraid that something bad is going to happen to you? | Yes | No |
| Do you feel happy most of the time? | Yes | No |
| Do you often feel helpless? | Yes | No |
| Do you prefer to stay at home, rather than going out and doing new things? | Yes | No |
| Do you feel you have more problems with memory than most? | Yes | No |
| Do you think it is wonderful to be alive? | Yes | No |
| Do you feel worthless the way you are now? | Yes | No |
| Do you feel full of energy? | Yes | No |
| Do you think that your situation is hopeless? | Yes | No |
| Do you think that most people are better off than you are? | Yes | No |

### c) Practitioner Assessment of Network Typology (Wenger, 1991)

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. How far away (in terms of distance) does your nearest child or other relative live? *(Includes related members of household, excludes spouse)* | No relatives | Within 1 mile | 1-5 miles | 6-15 miles | 16-50 miles | 50+ miles |
| 2. Do you have any children? If yes, where does your nearest child live? | No children | Within 1 mile | 1-5 miles | 6-15 miles | 16-50 miles | 50+ miles |
| 3. Do you have any living sisters or brothers? If yes, where does your nearest sister or brother live? | No children | Within 1 mile | 1-5 miles | 6-15 miles | 16-50 miles | 50+ miles |
| 4. How often do you see any of your children or other relatives to speak to? *(excludes spouse)* | Never or no relative | Daily | 2-3 times per week | At least weekly | At least monthly | Less often |
| 5. Do you have any friends in this community? If yes, how often do you have a chat or do something with one of your friends? | Never or no friends | Daily | 2-3 times per week | At least weekly | At least monthly | Less often |
| 6. How often do you see your neighbours to have a chat with or do something with? | No contact with neighbours | Daily | 2-3 times per week | At least weekly | At least monthly | Less often |
| 7. Do you attend religious meetings? | Yes, regularly | Yes, occasionally | No | | | |
| 8. Do you attend any meetings of any community or social groups, such as clubs, lectures or anything like that? | Yes, regularly | Yes, occasionally | No | | | |
| If yes, what do you attend? | | | | | | |

## An excerpt from a coded transcript

| | Transcript | Codes |
|---|---|---|
| I | If somebody said to you, Mr X, would you like to come to this club, what would you do or say? | |
| P | Nah | Refusing social invitations very quickly |
| I | You'd say no | |
| P | I wouldn't wanna, I wouldn't wanna know, no | |
| I | Can you tell me a bit about that, why would you say no? | |
| P | Cos I don't think they would be the same as what like I said they [my friends] used to be | Not wanting to mix with people who are not like me |
| I | Right | |
| P | I don't think they would be the same as like we used to be | |
| I | What do you think they would be like? | |
| P | Well it depends on whether, what it was all about wouldn't it really, what whatever whatever community they was, or associated with, you know what did they do, or what do they do for the people | |
| I | Mm, have you ever been invited to a group, or has anybody ever suggested for you to join a group? | |
| P | Well yeah I had a, somebody from the council been, wanted me to go to a a to a centre, but I told em what I just told you, I worked too in em, I didn't wanna go | Deciding not to interact based on negative predictions<br>Avoiding identification with old/sick/disabled people<br>Not wanting to mix with people who are not like me |
| I | You worked in them? | |
| P | Well taking the handicapped people | |
| I | And what is it about them that you didn't wanna go? | |
| P | Well they were, hard to say, it's hard to say that, they were handicapped unfortunately, but they didn't sort of mix or talk the way you used to do it, therefore, to me, there was no point in going | |
| I | Ah, how did they mix and talk? | |
| P | Pardon | Avoiding identification with old/sick/disabled people<br>Predicting that people at groups will be "lifeless"<br>Not wanting to mix with people who are not like me<br>Deciding not to interact based on negative predictions<br>Not wanting to mix in a way that is not like me |
| I | What did you see happen there? What was it like when you saw it? | |
| P | Well they just sat there and just looked at one another and er I wanted to be more jolly than that, there was no er no enjoyment in going to that at all, make you as miserable as sin, I know I'm old myself, but I can still mix with people, even now | |
| I | Yeah, yeah | |
| P | I mean if my friends were able to come here and say we're taking you out, I'd go | |
| I | OK | Wanting to mix with people I already know |
| P | And enjoy myself cos I know I would enjoy meself, so as I say, if me friends or anybody were to come here and say come on we're gonna take you out I would enjoy it yeah | |
| I | And which friends would it be that you would like to go with | |
| P | Pardon | |
| I | Which friends are they? | Wanting to mix with people I already know<br>Wanting to mix with people who are like me |
| P | They're friends from the [football team], er all the friends I mix with is [football team], that I've associated with over the years, going to many good times with them, and if they were to come here, and out I would go go go | |
| I | And what do you think you would do with them? | |
| P | Pardon | Wanting to mix with people I already know<br>Wanting to mix with people who are like me<br>Wanting to mix in a way that is like me |
| I | If they came here and you went with them, what do you think you would do together? | |
| P | Well, wherever they took me out, whether for a meal or or something and we'd have a laugh and a joke, and all that, you can't do otherwise can you, you go for a meal or what have you, and then you have a laugh, probably talk about old old times what we used to do | |

***N.B. The social identity of the participant in this extract was described as: husband, father, sports fan, joker.***

**KEY:** I, interviewer; P, participant.

## Themes and constituent codes

| Cluster 1. Overt barriers | |
|---|---|
| **Illness and disability** | Worrying about ability to manage mobility/health issues when out |
| | Feeling that health/mobility issues make it difficult to go out |
| | Feeling that health/mobility issues make it impossible to go out |
| | Feeling that going out is too much effort |
| | Feeling unable to go out due to caregiving role |
| | Being so preoccupied with health/mobility problems that I can't think about social interactions |
| | Difficulty managing transport |
| **Loss of friends and family** | Having less interaction with family than desired |
| | Losing interaction with a deceased spouse |
| | Losing interaction opportunities because friends/neighbours have died, become ill/disabled or moved away |
| | Having less support from others than desired |
| | Losing spouse as a "bridge" to social interaction |
| | Wanting to mix with people I already know |
| | Perceiving that there's no-one to contact/help |
| | Wanting (and lacking) someone else to come out with me |
| | Needing (and lacking) a friend to give me a lift |
| | Being reluctant to seek support from formal services |
| | Not wanting to interact with strangers/professionals/services |
| **Loss of community** | Perceiving a loss of community |
| | Perceiving a downfall of local services |
| | Experiencing less interaction with neighbours than desired |
| | Feeling unsafe in the local neighbourhood |
| | Perceiving a downfall of society |
| | Associating neighbourhood problems with the presence of other ethnic groups |
| **Perceived lack of social opportunities** | Being unaware of available groups/services |
| | Predicting that I won't like/be able to do offered activities |
| | Predicting that I won't like/be able to eat offered food |

| Cluster 2. Responses to barriers | |
|---|---|
| **Minimising the difficulties of loneliness** | Minimising/hiding my lack of interaction<br>Preferring own company/not wanting to interact<br>Accepting current situation |
| **Not seeking social interaction** | Accepting inadequate social interaction without asking for any more<br>Not asking for support<br>Feeling hopeless/defeated with regards to socialising<br>Perceiving going out/socialising as impossible |
| **Avoiding social opportunities** | Putting off interaction<br>Refusing social invitations very quickly<br>Deciding not to interact based on negative predictions |
| **Relying on the telephone** | Interacting by means other than face-to-face |
| **Keeping busy with solitary activities** | Engaging in solitary activities |

| Cluster 3. Social fears | |
|---|---|
| **Fear of rejection** | Fearing being let down<br>Fearing that others at the group might gossip/talk about me<br>Withdrawing from social situations due to social fears<br>Fearing social "failure"/being shamed/humiliated<br>Fearing exclusion/rejection<br>Fearing having to talk about personal matters |
| **Fear of exploitation** | Fearing that interaction will harm rather than help me |

| Cluster 4. Fear of losing preferred identities | |
|---|---|
| **Fear of losing "independent" identity** | Feeling undeserving of support |
| | Not wanting to be a burden |
| | Wanting to remain self-sufficient |
| | Wanting to support others |
| **Fear of losing "youthful" identity** | Feeling that I am "too old" |
| | Avoiding identification with old/sick/disabled people |
| | Predicting that people at groups will be "lifeless" |
| | Avoiding being around "old" people because it will make me "old" |
| | Seeking proximity to “young” people because it will make me “young” |
| | Fear/experience of discrimination/stigmatisation/rejection on basis of age/disability/illness |
| **Fear of losing preferred social identity** | Wanting to mix with people who are like me |
| | Perceiving a lack of people/services that are for people like me |
| | Wanting to mix in a way that is like me |
| | Not wanting to mix in a way that is not like me |
| | Perceiving a conflict between society and people like me |
| | Not wanting to mix with people who are not like me |
| | Wanting my old life/sense of self back |
| | Being unable to continue with activities that are like me |
| | Engaging in solitary activities that are like me |

## Project documentation

The below-listed study documents are provided on subsequent pages.

a. **Ethics approval letter**
b. **Recruitment leaflet**
c. **Information sheet**
d. **Consent form**
e. **Summary of findings for practitioners and commissioners**

**2UCL RESEARCH ETHICS COMMITTEE**
**GRADUATE SCHOOL OFFICE**

Dr Katrina Scior
Clinical Psychology
4th Floor, 1-19 Torrington Place
UCL

6 February 2013

Dear Dr Scior

**Notification of Ethical Approval**
**Project ID: 4454/001: Service access and social identity in lonely older adults**

I am pleased to confirm that your study has been approved by the UCL Research Ethics Committee for the duration of the project i.e. until January 2015.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

   **Reporting Non-Serious Adverse Events**
   For non-serious adverse events you will need to inform Helen Dougal, Ethics Committee Administrator (ethics@ucl.ac.uk), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

   **Reporting Serious Adverse Events**
   The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

With best wishes for the research.

Yours sincerely

[redacted]

**Professor John Foreman**
**Chair of the UCL Research Ethics Committee**

Cc: Ms Johanna Goll

# Older people and community services in London

**We would like to invite you to take part in a research project.**

**What is the research about?**

- We want to find out what older people think about groups and services in their local area. By groups and services we mean things like: social groups, lunch clubs, activity groups, and befriending services.
- We want to speak to older people who
  (1) tend **not** to go to groups and services
  ***and*** (2) sometimes **feel separate from other people**.
- We want to find out how older people describe themselves, and how this affects their choices about attending groups and services.
- We hope that this project will help us develop the kinds of services that older people in London would like.

**What will the research involve?**

- The main part of the research consists of **one interview** with a researcher.
- You will be asked questions about how you describe yourself as a person, and about how this affects your views of groups and services.
- The interview will last between 1 hour and 1 ½ hours, but it can be split into two shorter interviews if you prefer.
- The interview can take place in a location of your choice, such as your home, a local community building, a local café or the library.
- You will also be asked to complete **3 very short questionnaires**.
- You may also be invited to talk to us about your interview a few weeks after it has happened, to give some feedback; however, this part is **optional**.
- You will receive a **£10 supermarket voucher** to thank you for your time, if you are suitable for the project and you take part.

## Who can take part?

- We are looking for people who fit the following description:
  1. Aged 65 or older
  2. Able to speak English well enough to take part in an interview
  3. Tend **not** to go to groups and services
  4. Sometimes feel separate from other people
- Unfortunately, if you don't fit all 4 descriptions, you may not be able to take part.
- If you are unsure about whether you can take part, please contact the main researcher, Johanna Goll to find out more (her contact details are provided below). She will be very happy to talk to you and answer any questions.

## Do I have to take part?

- You **do not** have to take part.
- It is up to you to decide whether you would like to take part. You may like to spend some time thinking about it first, or you may like to talk it over with someone else.
- Choosing not to take part will not disadvantage you in any way. For example, it will **not** affect the services that you receive.
- If you agree to take part, you are **free to stop at any time** without giving a reason.

## Are there any risks involved in taking part?

- It is not expected that taking part will cause you any harm.
- The project involves talking with a researcher (to do an interview), and does not involve any other procedures, or treatments. Some people may find that the interview causes them to think or talk about personal or upsetting topics. However, you do not have to answer all the questions, and you can choose to stop the interview at any point. Additionally, all your information will be kept confidential (for more details about this, see the section below called "What will happen to the information that I give?").

## Are there any benefits to taking part?

- If you are suitable for the project, and you take part, you will receive a **£10 supermarket voucher** to thank you for your time.
- Other than this, there are no direct benefits of taking part. However, it is hoped that the project will help to develop services that older people would like.
- Some people benefit from the chance to talk to someone else during an interview.
- Additionally, some people enjoy finding out about the results of the project when it is finished, and we will provide this opportunity for anyone who is interested.

## What will happen to the information that I give?

- With your permission, your interview will be audio recorded so that it can be transcribed (written down) afterwards. Any information that would allow others to recognise you (e.g. your name) will **not** be included in the transcription. Once the transcription is complete, the recording will be deleted.
- All information (audio recordings, transcriptions, questionnaires) will be treated as **confidential**, and kept in accordance with the Data Protection Act (1998). This means that the information that you give us will be **well protected**. For example, your information will be marked with a code rather than your name, so that you cannot be recognised (information will be kept **anonymously**). Additionally, your information will be stored securely, so that only the researchers working on the project can access it.
- However, if we became **extremely** concerned about your safety or the safety of another person, we would have to break confidentiality. In this type of situation, it is our duty to get in touch with other professionals (like your GP) so that they could protect you (or another person) from harm. We would always try to discuss a situation like this with you before contacting any other professionals.

## Will the results be written up and published?

The results of the project will be written up in a report and shared with local organisations including Age UK. Results may also be published in a professional journal. However, reports will include **general results only**. They will **not** contain any personal information that would allow you to be recognised. It is hoped that these reports will help organisations to develop the kinds of services that older people would like.

## Who is conducting this project?

This project is being conducted by a small team of researchers from University College London (UCL), with the support of Age UK. All members of the research team have undergone **satisfactory criminal record checks** (enhanced Criminal Records Bureau (CRB) checks). Additionally, the project has been **approved by the UCL Research Ethics Committee** (Project ID Number 4454/001).

- If you choose to take part, the person who you will meet and talk to is **Johanna Goll**. Her contact details are as follows.
  Post: Room 436
  Research Department of Clinical, Educational and Health Psychology
  FREEPOST University College London
  London WC1E 6BT
  Phone: [redacted]
  Email: j.goll@ucl.ac.uk

- The person in charge of the project is **Dr Katrina Scior**. Please feel free to contact her if you have any concerns or complaints. Her contact details are as follows.
  Post: Room 436
  Research Department of Clinical, Educational and Health Psychology
  FREEPOST University College London
  London WC1E 6BT
  Email: k.scior@ucl.ac.uk

**Please feel free to contact Johanna (by phone, email or post) if would like any further information about the project. She will be very happy to talk to you and answer any questions.**

**Thank you for taking the time to read this information sheet.**

**Your help makes our research possible.**

Participant Consent Form

# Older people and community services in London

**Do you want to take part in this project?** (Please tick the appropriate box)

☐ **Yes**, I would like to participate in this project.

☐ **No**, I do not want to participate in this project.

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**If you have answered Yes, please tick the following statements if you agree with them:**

☐ I have read the Information Sheet about the project, OR it has been read to me.

☐ I understand what is involved in taking part in the project.

☐ I understand that any information I give will be kept confidential and well protected.

☐ I understand that I do not have to take part in the project if I do not want to.

☐ I understand that I may stop taking part in the project at any time without giving a reason.

☐ I have had the opportunity to ask any questions I wish.

☐ I have had enough time to think about the project.

☐ I have the names and contact details of the people running the project. I understand that I can contact them if I have any further questions or concerns.

☐ I understand that I will receive a £10 supermarket voucher after I have participated, to thank me for my time.

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Name: ______________________________ Date: ________________________

Signature: ___________________________

***Thank you!***