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Timely Considerations of Using the de Jong Gierveld Loneliness Scale with Older Adults Living in Long-Term Care Homes: A Critical Reflection

RESEARCH

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ABSTRACT

Context: Despite being widely used with older adults in the community, there is limited literature on using the de Jong Gierveld Loneliness Scale with older adults living in long-term care (LTC).

Objective: The purpose of this article is to discuss the considerations of using this scale with older adults in LTC.

Method: Our team consisted of older person and family partners, a clinician, and academic researchers working together in all stages of research using the Loneliness scale to conduct individual interviews with 20 older adults in LTC in Vancouver, Canada, as part of a study exploring the experience of loneliness during the COVID-19 pandemic. Team reflection was embedded in the research process, with reflection data consisting of data transcripts, field notes, and regular team meeting notes. Thematic analysis was employed to identify lessons learned and implications.

Findings: Participants had various challenges responding to the scale. Our analysis identified five themes: a) diverse meanings of loneliness, b) multi-faceted factors of loneliness, c) technical challenges, d) social desirability, and e) situational experience. We also offer five recommendations to consider when using this scale with older adults in LTC.

Limitations: We used this scale with a small sample of older adults in LTC, which is a more time and labour-intensive population. Data on marital status and educational background was not collected but might help in understanding considerations for using the scale with older adults in LTC.

Implications: We offer practical recommendations for using the scale with older adults in LTC, especially how qualitative open-ended questions can complement the scale by providing useful insights into context and complex experiences.

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BACKGROUND

RESIDENT LONELINESS IN LONG-TERM CARE (LTC)

Loneliness is a subjective experience in which a person feels a lack of meaningful relationships (McMullan et al., 2021). There are two dimensions of loneliness (de Jong-Gierveld & van Tilburg, 2006): emotional loneliness coming from an absence of close relationships and social loneliness coming from an absence of social group or network.

Loneliness in LTC has been identified as a particularly acute problem; the prevalence of 'severe loneliness' reported by care home residents (22–42%) is more than twice that of older people in the wider community (10%) (Victor, 2012). Furthermore, a 2011 survey study suggests that institutionalized older adults are more likely to feel lonely due to reduced social opportunities compared to older adults living in the community (Prieto-Flores et al., 2011).

Recent qualitative studies have investigated how the COVID-19 pandemic has affected levels of resident loneliness in LTC. Rasnaca and colleagues (2022) interviewed social workers in LTC and reported social isolation due to visitation restrictions is a major contributing factor to resident loneliness during the pandemic. Both Huang and colleagues. (2022) and Jansson and colleagues (2022) recently explored residents' perspective of loneliness as well. Huang and colleagues (2022) interviewed residents to understand experiences of loneliness and suggested that LTC facilities should strive to maintain meaningful relationships between residents and their families, provide companionship with residents, and provide residents a sense of belonging to alleviate resident loneliness. Jansson and colleagues (2022) used ethnography to explore the experience of loneliness of residents in LTC. They reported experiences of resident loneliness in the context of different dimensions of loneliness. Given the growing literature on resident loneliness, robust and feasible assessments of loneliness is needed to fully understand the loneliness older people experience in LTC.

One loneliness measure is the widely used de Jong Gierveld Loneliness Scale. However, there is limited literature on the use of the scale with older adults living in long-term care (LTC). What are some considerations when administering a scale to capture loneliness in older adults living in LTC?

THE DE JONG GIERVELD LONELINESS SCALE

The original version of the de Jong Gierveld Loneliness Scale is 11 items (de Jong-Gierveld & Kamphuls, 1985). Due to feedback that the original version was too long to be implemented in a large survey, the scale was later shortened to 6 items (de Jong-Gierveld & van Tilburg, 2006). Both the 11-item and 6-item versions are bi-dimensional and capture the social and emotional aspects of loneliness (de Jong-Gierveld & Kamphuls, 1985; de Jong-Gierveld & van Tilburg, 2006).

Both versions were tested with older adults in different countries and languages. The following are some examples and is not an extensive list. The 11-item version was found to be reliable and valid among older adults living in the community in Canada when administered in English (Penning, Liu & Chou, 2014), Spain when administered in Spanish (Buz & Pérez-Arechaederra, 2014), and Iran when administered in Persian (Hosseinabadi et al., 2021). The 6-item version was found to be reliable and valid among older adults living in the community in the Netherlands when administered in Dutch (de Jong-Gierveld & van Tilburg, 2006) and in Hong Kong when administered in Chinese (Leung, de Jong Gierveld & Lam, 2008). The 6-item version was also reliable and valid among non-Indigenous older adults living in the community in Chile when administered in Spanish (Rodrigues et al., 2021).

The two versions have also been widely used to assess loneliness of older adults living in the community. De Jong-Gierveld and van Tilburg (1999) used the 11-item version to assess loneliness of older adults living in the community in Italy and the Netherlands and found that living with family is a factor that reduces loneliness in Italy but increases loneliness in the Netherlands. Weinstein and colleagues (2016) adopted the 11-item version to examine whether wearing hearing aids reduces the sense of loneliness of older adults living in the community and found that it helps reduce loneliness. Fokkema and Naderi (2013) used the 6-item version to assess and compare loneliness of older adults living in the community in Germany who were native born or immigrated from Turkey. The authors found that those who immigrated from Turkey felt lonelier.

Even though there is a wide range of literature on using the scale with older adults, most literature is with older adults living at home. There are limited studies using the scale with older adults living in LTC.

One study by Iecovich (2013) validated the 11-item version for reliability and validity among three groups of older adults in Israel in Hebrew: living at home without care, receiving LTC and home care, and receiving day care. While this study was one of the few which considered older adults living in LTC, the study did not differentiate between the three groups of older adults, so we do not know whether the results would be different if it was only used among older adults living in LTC.

Mann and colleagues (2020) used the 6-item version to examine the loneliness of older adults with sight loss living in LTC in the United Kingdom. They were not able to collect enough data for analysis because they found it challenging to administer the scale to participants, who had difficulty understanding the wording of the scale items. Due to their sight loss, participants were also not able to perceive non-verbal cues from researchers to

better understand the meaning of scale items. Although the study provided some insights on the application of the scale among older adults living in LTC, it only focused on older adults with sight loss.

More research is needed to further explore the practical utility of the scale for older adults living in LTC: what works, what does not, why, and how. This article is a critical reflection of our experience using the scale with older adults living in LTC. Our team consists of older person and family partners, a clinician, and academic researchers working together in all stages of research. Based on our experience of using the scale with older adults living in LTC, we offer lessons learned and practical recommendations. By addressing the gap in the literature, we hope to provide key insights on using the scale with older adults living in LTC to guide future use and research.

THE OVERCOMING LONELINESS PROJECT

The application of the scale is part of a larger study called the Overcoming Loneliness project, which aims to understand loneliness in LTC during the COVID-19 pandemic. The study took place in two large urban LTC homes in Vancouver, Canada, with substantial outbreaks and fatalities (Mackenzie, 2021). The resident population is multicultural and has various complex needs, requiring 24-hour nursing care. From the beginning of the pandemic in 2020, residents faced restrictions, such as having limited mobility within the care home. Both LTC homes underwent a strict lockdown during outbreak periods for about two and a half months starting at the end of 2020. During this period, residents were confined to their rooms and had minimal contact with staff. By mid-2021, residents were able to move between floors and leave the care home. Visitation also slowly began again.

We conducted individual interviews by videoconferencing through a telepresence robot (Double Robotics, 2022). Videoconferencing was used due to ongoing limitations on visitation in the care homes. The study was approved by the Research Ethics Board at the (name of the university) and the local health authority. The names used in the article are pseudonyms.

As part of the larger study, researchers interviewed 20 residents in LTC. The inclusion criteria were residents living in one of the two care homes and the ability to share their experience, and there was no specific exclusion criterion. A convenient sampling method was used for recruitment; study posters were used to invite participants, and the recreation staff members who knew the residents well also helped recruit participants. All participants gave written informed consent. Participant characteristics are reported in Table 1.

RESIDENT CHARACTERISTICS	%
Age (Years)	
60–75	10
76–85	80
Older than 85	10
Gender	
Male	40
Female	60
Ethnicity	
Caucasian	80
South Asian	20

Table 1 Characteristics of the participants.

Our research team conducted individual interviews by videoconferencing through a telepresence robot, which allowed our older person partners to conduct remote interviews with visual and audio interactions in long-term care homes. The telepresence robots offered good quality and volume of audio for older residents. They can be remotely adjusted for height and position with the interviewer's face to provide a natural physical presence feeling. More information can be found in another paper (blinded for review). The interviews were conducted from September to December 2021. Each lasted for approximately 30–60 minutes. Data were recorded and transcribed verbatim. Fieldnotes were also taken.

The interview included two parts. The first part was the scale. The second part was a semi-structured interview asking participants about their understanding and experience of loneliness. Including open-ended questions in the semi-structured interview allowed us to supplement and compare the results of the scale to the more detailed responses from the participants to better understand their experiences of loneliness. This article will focus on our experiences of administering the scale.

In the beginning of our data collection, we used the 11-item version of the scale and adopted the Likert scale with five options (none of the time, rarely, some of the time, often, all of the time) (de Jong-Gierveld & Kamphuls, 1985). After a few initial interviews, participants reported that the scale was too long, confusing, and difficult to understand. Therefore, we switched to the 6-item version and adopted the Likert scale with three options (yes, more or less, no) (de Jong-Gierveld & van Tilburg, 2006).

PROCESS OF TEAM REFLECTION

We applied the critical reflection framework of Rolfe, Freshwater, and Jasper (2001) for reflective practice, which includes (a) What (context), (b) So what (lessons learned), and (c) now what (implications). We are a team

made of frontline clinicians (a nurse), two older person partners (one of them self identifies as a person living with dementia) and two family partners, academic researchers (a professor, a postdoctoral fellow, a PhD student, and an undergraduate student). The older person and family partners were recruited from the local Community Engagement Advisory Network (CEAN). The full team, including the older person and family partners, contributed to the study at every stage of the process, including research design, data collection, data analysis, and knowledge translation.

The perspectives of older person partners with lived experience improve the value and quality of research. As suggested by Greenhalgh and colleagues (2019), engaging patient partners (people with lived experience) in the research team increases the accountability, relevance, and transparency of the research.

We had regular biweekly one-hour virtual meetings by Zoom throughout the study, facilitated by one of the authors (initials of the author), who is a professor and has extensive training and experience on patient-oriented research. These meetings took place over one year, both in preparation for and during data collection. The older person and family partners previously collaborated with (initials of the author) in other research projects and joined this study because of common interests in the topic of the research. We took detailed meeting notes and communicated by email. The first author (initials of the author) kept a research journal to document the research process.

In the research design stage, we chose the scale together with older person and family partners, who then pilot-tested the scale. In the data collection stage, the older person and family partners, along with the undergraduate student, employed the scale to measure loneliness of LTC resident participants during the interviews. We critically reflected and discussed our challenges and experiences in our regular research meetings. The data for this reflection paper was generated from data of the scale, transcripts of the interviews, field notes during the data collection, notes from biweekly team meetings, email exchanges, and the research journal.

Thematic analysis (a six-step approach) was performed to analyze the data (Braun & Clarke, 2006). First, we read and re-read the data to gain familiarity. Second, the first author inductively coded the data. Third, data were sorted into preliminary sub-themes and then grouped into themes. Fourth, the whole team reviewed the themes, systematically compared and carefully examined the themes, and found common and divergent patterns among the themes. Fifth, we collectively developed five empirically grounded themes. Finally, we prepared the findings as presented in the next section.

RIGOR

We used a reflexive approach to enhance trustworthiness of the study. Our team reflection allowed us to discuss and compare our own assumptions and paid attention to how assumptions might influence our thinking and actions. In the concurrent data collection and analysis process, we asked what worked well and what did not, and we explored and co-developed strategies for robust results. Fieldnotes were taken to capture analytical thoughts and iterative analysis. To establish dependability, we offer a rich description of study context and methods. For credibility, including older person and family partners and clinicians in the research team helped to demonstrate a recognition of experiential knowledge. Our team reflexive meetings helped bring a more comprehensive understanding of the complexity of clinical situations and experiences in LTC homes.

LESSONS LEARNED ON USING THE SCALE WITH OLDER ADULTS LIVING IN LTC

Based on the data related to our experience of administering the scale, the following are our critical reflections of using the scale with older adults living in LTC. Direct results of the Overcoming Loneliness study using the de Jong Gierveld scale are reported elsewhere (blinded for review); here, we present our reflections based on our experiences of using this scale.

1. DIVERSE MEANINGS OF LONELINESS

After completing the scale, we asked participants what loneliness meant to them in the semi-structured interviews. We found that the scale does not capture some dimensions of loneliness defined by participants in our study. For instance, some participants defined loneliness as being out of control of your life, but this dimension is not captured by any item of the scale: When asked what loneliness meant to her, participant Isabel (female) said, *'You're not in your home… in an institution for seniors and it takes a little bit for getting used to, so a feeling of dissociation and lack of control of your situation.'* Participant Mia (female) said, '*Losing your control in your life, can't even control your situation and whether or not you want to be alone. Losing the ability to do volunteering, dedicate your life to others.'*

Another dimension of loneliness that was not captured by the scale was feeling isolated from people outside of the care home. For example, participant Liam (male) did not seem lonely according to scale, but his responses were based on his connection with staff. It was the staff who he felt he could rely on and trust. He indicated that the presence of the staff helped mitigate feelings of loneliness. However, the questionnaire did

not specify his view of his connection with friends and family outside of the home. In the interviews, he further explained, *'I didn't see my friends for over 2 years, so I'd like to see them again. I want to get out of here and get an apartment so I can see my friends because I can't see them in here. I don't know where they are.'* The difference between the scale rating and later responses to the questionnaire reflects how the de Jong Gierveld scale may not fully capture what loneliness means to older people in LTC.

2. MULTI-FACETED FACTORS OF LONELINESS

Researchers will hardly know the reasons behind participants' scores on the scale without further questions. Participants may score similarly on the scale, yet the reasons vary. For example, participants Charlotte (female) and Mia (femal) reported high scores on the loneliness scale, but the reasons behind why they felt lonely were very different. The reasons were not known until our in-depth interviews with them: Charlotte lost her spouse, and Mia felt she lost control of life because of her decline in health and functionality.

Practitioners often use the scale to assess loneliness and to provide interventions accordingly. The government also uses the scale to understand how many people are lonely and allocates resources to overcome loneliness correspondingly. However, the reasons behind people's loneliness vary. If practitioners and the government only refer to scores on the scale and do not understand the reasons behind the scores, they may have ineffective interventions and policies. For example, while reducing the sense of isolation in LTC may help mitigate loneliness for some residents, it may be ineffective for others.

3. TECHNICAL CHALLENGES

According to our observation during the interviews, the scale had a few technical challenges for participants. First, participants were confused when they felt multiple items were too similar. For instance, Liam confused the items "I miss having people around" (item 9) and "I often feel rejected" (item 10) of the 11-item version:

> *Researcher: Would you say that you miss having people around you?*
> *Liam: No, not really. I'm not a lonely person.*
> *Researcher: Would you say that you often feel rejected?*
> *Liam: No, there's always nurses around here, so you don't have time to get lonely.*

From the above conversation, we can see that when the researcher asked if Liam felt rejected, he thought the researcher was still asking if he felt if he missed having people around him. It also showed that he did not understand the second question.

Second, it was difficult for participants to choose the options, even after the Likert scale had been limited down to 3 options. In the following example, the researcher asked Emma (female) to choose among the options yes, more or less, or no for the item 'there are many people I can trust completely.' Emma said, *'(Thinking for 10 seconds) There certainly aren't many people … It's probably a couple but not many … I guess more or less? There are some but not that many.'*

From here, we can see that Emma struggled with what she should choose for her answer. She had people who she could trust, but not many. Participants may not know how to interpret the response 'more or less', suggesting an alternative response option should be considered. Mann and colleagues (2020) suggested the use of yes and no responses only, which may make response options clearer for participants.

Some participants also did not know how to interpret some of the scale items. For example, in response to 'there are enough people I feel close to' (item 8 of 11-item version and item 6 of 6-item version), Olivia (female) chose not to respond because *'it is a very vague question to answer.'*

Furthermore, for the 6-item version, the first three questions are negative statements, while the final three are positive statements. Some participants seemed to be defensive by the third question and felt the researcher was being negative.

Finally, the scale was too long for some participants to stay focused, even the 6-item version. According to the observation of researchers, some participants appeared exhausted by the end of the questions. For example, it took 40 minutes for a participant to complete the 6-item scale. The researcher was told that this participant has dementia and seemed to have attention difficulties. The scale also seemed to be particularly challenging for other participants with dementia. This may be because the questions in the scale tended to ask participants to recall past experiences and feelings, which could be challenging for people with dementia. This point will be further elaborated later in Situational Experience.

4. SOCIAL DESIRABILITY

Social desirability in a research context means that participants give responses that they consider to be socially desirable or do not give responses that they consider to be socially undesirable, although these responses may not be genuine responses (Fastame & Penna, 2012). Based on our observations during interviews, social desirability may have occurred in our study.

In the following example, the researcher asked participant Amelia (female) what she thought about the item 'you often feel rejected,' and Ameilia said: *'Not at all. This is all negative and I know number one negative is*

not for me, so I walked into a group and I feel like they're negative I just walk out.'

From the above example, although Amelia said that she felt 'not at all' in response to the item 'you often feel rejected,' it appeared that Amelia did experience feeling rejected by a group of people, as she could feel they were negative. She answered 'not at all' for the item, likely because she considered that feeling rejected was negative and it was not polite (socially undesirable) to say that she feels rejected.

In the following example, the researcher asked participant Olivia (female) what she thought about the item 'there are plenty of people I can rely on when I have problems.' Olivia hesitated to give her answer and said:

> *'I don't want to answer that question because to me, I feel most people do care about me. I know who (the staff) to look for and who to talk to because even I have their extension. When I find there's a need to talk, who is the person I want to appoint, whoever I feel that is the person, I want to look up. "I like to talk to you. I look forward to." Or I come up to (the receptionist)'s extension I say "hi (receptionist)" I just go straight to the point and ask for it. Unless I don't know who to, then I'll ask the nurse.'*

From the above example, Olivia felt most staff in LTC cared about her, but she hesitated to give an answer to the item 'there are plenty of people I can rely on when I have problems.' One possible reason was that it was socially undesirable to say that she could not rely on staff who cared about her.

Other participants also seemed cautious of their responses because they did not want to be seen as speaking poorly about the staff. For example, Isabel questioned the researcher about the motivation of the questions, particularly on how it may relate to staff whom she felt were doing a great job. The field notes described that Isabel was noticeably upset and defensive. The distrust that can develop due to questions such as 'I often feel rejected' (item 10 in 11-item version and item 3 in 6-item version) or 'there are many people I can trust completely' (item 7 in 11-item version and item 5 in 6-item version) may further lead to participants providing socially desirable answers, particularly when the participants answer these questions in reference to the staff, whom may be their primary source of support and socialization. Participants may feel the staff could get in trouble if they do not provide positive answers.

In each example, participants appeared to give answers that they considered socially desirable and not to give answers that they considered socially undesirable. It could be difficult for the researchers to be aware of the social desirability of participants unless researchers reflected on the interview process, just like what we were doing in this section.

5. SITUATIONAL EXPERIENCE

Self-reported measures rely on respondents' recall on experience of the construct (at the time of responding), and this scale is designed to get a general sense of loneliness of participants over a period of time. However, memory declines as we age (Murman, 2015), and people living with dementia may have challenges recalling past experiences or feelings (World Health Organization, 2021). Using the de Jong Gierveld scale, our study asked participants to recall feelings of loneliness particularly about the time of strict isolation protocols, which was between December 2020 and March 2021. Some participants answered according to how they felt during the time of the interview, which was five to eight months after the isolation period.

Also, because participants tended to respond based on their current feelings, their sense of loneliness could easily change by what was happening during the interview. For example, participant Sophia (female) said she was lonely at the beginning of the interview, but she appeared less lonely when a nurse who she saw as her friend came into her room.

RECOMMENDATIONS FOR USING THE SCALE WITH OLDER ADULTS LIVING IN LTC

Based on our critical reflections (analysis) about using the scale with older adults living in LTC, we propose the following five recommendations.

1. FURTHER EXPLORING THE DEFINITION OF LONELINESS

Future researchers may conduct a study to understand how older adults living in LTC define loneliness. Akhter-Khan and Au (2020) argued that loneliness is a complex and heterogeneous concept. The authors suggested researchers do not fully understand the complexity of loneliness and need to further explore this concept. This suggestion expands on the work by Jansson and colleagues (2022), who suggested there are multiple and distinct dimensions of loneliness in LTC facilities. Given the heterogeneous definitions of loneliness among residents in our study, residents may understand loneliness as aligning with certain dimensions over others. Approaching loneliness as a multifaceted concept with multiple dimensions is recommended.

Researchers may reconsider the items of the scale according to how older adults in LTC define loneliness. Some participants in our study defined a sense of being out of control of their lives or having full control of

choosing to be alone or with others as a part of loneliness. Researchers may consider asking more questions about autonomy and having control to make decisions. This resonates with Heu and colleagues (2021), who suggested that a remedy to loneliness is to gain higher independence from others.

2. TECHNICAL ADJUSTMENTS

According to our study, participants considered some items too similar or vague. Researchers may consider revising the wording of the items to make them clearer to participants. As suggested, the item 'I often feel rejected' was confusing. This might be because the word 'rejected' was too abstract. We suggest elaborating to 'not being accepted.' This wording may better capture one of the themes related to resident loneliness in LTC identified by Huang and colleagues (2022) of 'lacking a sense of belonging'.

Considering that the scale may be too long for participants, researchers should check in with participants to see if they need a break during the interview. Researchers should consider using the 6-item instead of the 11-item version. Researchers should provide participants with a printout of the scale during or prior to the interview so they can view the statements and responses visually rather than expecting them to memorize all the potential responses in their mind, which is particularly difficult for the 11-item version that has five response options. It may be beneficial to mix the positive and negative scale items in the 6-item version, similar to how the items are mixed in the 11-item version. This may prevent the participants from feeling defensive in their responses and questioning the intentions of the researchers. However, mixing the responses may confuse participants as they switch from positive to negative statements and the feelings associated with those statements.

3. HANDLING SOCIAL DESIRABILITY

Social desirability was a challenge not only in our study, but also in other studies using scales with older adults (Chan, To & Wong, 2015; Fastame & Penna, 2012; Soubelet & Salthouse, 2011). Researchers may consider taking field notes on the interview process after the interviews and later reflecting on the field notes to see if they identify any possible socially desirable responses of participants. If researchers suspect social desirability, they should treat the data carefully and consider that the data may not fully reflect true responses. Researchers should make a note of the limitation and reconsider whether using the scale is the best way to understand the loneliness of their studied population (Fastame & Penna, 2012; Soubelet & Salthouse, 2011).

For participants who can complete the scale by themselves, researchers may consider letting participants complete it privately. Not having a researcher with them may reduce their pressure to give socially desirable answers. For participants who have physical challenges writing down the answers, such as hand tremors, researchers may consider giving participants a piece of paper with the scale questions and an audio recorder so that participants can easily record the answers by themselves.

Researchers should also emphasize that the participants' responses are confidential and ensure the participant understands the purpose of the use of this scale is to understand their experience of loneliness rather than penalize the staff involved in their care based on their responses.

4. CONDUCTING INTERVIEWS AT DIFFERENT TIMES AND DAYS

Because people living with dementia tend to think in the present, it may be more beneficial to invite participants to complete the scale at multiple points throughout the day and on different days. Researchers can then compare participants' answers between different times and days. However, completing the scale multiple times may increase participant burden and result in participants feeling anxious. Also, loneliness may provoke feelings of sadness among participants, further increasing participant burden. Older adults living in LTC are often vulnerable, and adding emotional burden may not be appropriate.

5. USING QUALITATIVE OPEN-ENDED QUESTIONS AS COMPLEMENT

Our study provides important insight by combining results from the scale and semi-structured interviews to permit critical analysis of the scale's reflection on participants' perspective of loneliness. Future researchers may consider using qualitative open-ended questions as a complement to understand the loneliness of older adults living in LTC. Open-ended questions allow participants to elaborate on their answers and the researchers to ask follow-up questions. Researchers can also understand the context of why participants feel lonely. These benefits of using open-ended questions can be found in the literature about understanding loneliness of older adults living in LTC (Huang et al., 2022). As suggested, our study consists of the scale and a semi-structured interview on participants' understanding and experience of loneliness. According to the researchers' observation, participants appeared to respond more easily during the qualitative interviews than the scale, because an interview was more like a conversation. Giving participants the opportunity to describe their experiences through interviews may encourage rapport building with the researcher, which may help participants to feel more comfortable speaking about their experiences and to be honest in their responses.

A potential strategy of helping participants reflect on their experience before using the scale is asking the open-ended questions before administering the scale. The use of open-ended questions at the beginning of an interview allows residents to take time to reflect on and describe their experiences, which may help them better understand their own experience of loneliness when responding to the scale afterwards.

LIMITATIONS

The sample of older adults was relatively small. However, it is important to consider that using the scale with older adults living in LTC involves more time and and is more labour-intensive than with other populations. Also, we did not collect data on the marital status and educational background of this sample. These characteristics might help us to understand the considerations for using this scale with the LTC population.

CONCLUSION

This article presented our research team's experience using the de Jong Gierveld Loneliness Scale to measure loneliness among older adults living in LTC, as part of a larger study on understanding loneliness in LTC. There is limited literature on using the scale with this population, and this article expands the literature. The purpose of our paper is to understand what the considerations are when using this scale with the LTC population. Older adults had various challenges responding to the scale. Our analysis identifies five themes: a) diverse meanings of loneliness, b) multi-faceted factors of loneliness, c) technical challenges, d) social desirability, and e) situational experience. We also offered five preliminary recommendations for using this scale for future research based on our lessons learned. This study sheds light for future research using the scale with this population.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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