Original Research / Orijinal Araştırma

Factors Affecting the Level of Loneliness Among Elderly Receiving Home Care Services

Evde Bakım Hizmeti Alan Yaşlıların Benlik Saygısı ve Yalnızlık Düzeyi Arasındaki İlişki

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Abstract

Objective: The primary aim of this study was to identify and understand the factors contributing to loneliness among individuals aged 65 and above receiving home care services.

Methods: This research adopted a cross-sectional descriptive design to investigate the factors influencing loneliness in the elderly population. The study's population comprised individuals aged 65 and above receiving home care services from a municipality in Istanbul. The sample, determined through the convenience sampling method, consisted of 285 older participants who volunteered to take part in the study and were actively receiving home care. Data were collected using three main instruments: The Personal Information Form, The Loneliness Scale for the Elderly, and The Rosenberg Self-Esteem Scale.

Results: The loneliness level among single elderly individuals was significantly higher than that of their married counterparts, with being single explaining 33% of the variation in loneliness (R^2 = 33). The engagement in social activities emerged as a crucial factor, as the loneliness levels of socially active elderly individuals were notably lower, contributing to 25% of the variation in loneliness (R^2 = 25). The Rosenberg Self-Esteem Scale revealed that as the self-esteem of older adults increased, their loneliness levels decreased, explaining 26% of the variation (R^2 = 26). Marital status, social activity, and self-esteem variables collectively explained 23% of the variation in the level of loneliness.

Conclusion: The study's key findings indicate that the level of self-esteem among elderly individuals receiving home care services was moderate. Additionally, single elderly individuals experienced higher levels of loneliness compared to their married counterparts. Socially active older adults exhibited lower loneliness levels, and increased self-esteem corresponded to decreased loneliness. Notably, variables such as age, gender, educational status, and the presence of chronic diseases showed no significant impact on the level of loneliness among the elderly.

Keywords: Public health, social isolation, loneliness, old age

Özet

Amaç: Bu çalışma, evde bakım hizmeti alan 65 yaş ve üzeri bireylerde yalnızlığa katkıda bulunan faktörlerin ortaya çıkarılmasını amaçlamıştır.

Gereç ve Yöntem: Kesitsel tanımlayıcı bir tasarımı benimseyen bu araştırma, yaşlı nüfusta yalnızlığı etkileyen faktörleri araştırmaktadır. Araştırmanın evrenini İstanbul'daki bir belediyeden evde bakım hizmeti alan 65 yaş ve üzeri bireyler oluşturmuştur. Kolayda örnekleme yöntemi kullanılmış ve örneklemi aktif olarak evde bakım hizmeti alan 285 yaşlı birey oluşturmuştur. Veri toplamada Kişisel Bilgi Formu, Yaşlılar İçin Yalnızlık Ölçeği ve Rosenberg Benlik Saygısı Ölçeği kullanılmıştır.

Bulgular: Bekar yaşlı bireyler arasındaki yalnızlık düzeyleri, evli olanlara göre önemli ölçüde daha yüksek bulundu; bekarlık, yalnızlık varyasyonunun %33'ünü açıklıyordu (R^2 = 33). Sosyal açıdan aktif yaşlı bireylerde, belirgin şekilde yalnızlık seviyeleri daha düşüktü, varyasyonun %25'ine katkıda bulundu (R^2 = 25). Yaşlı yetişkinlerin benlik saygısı arttıkça yalnızlık düzeylerinin azaldığı bulundu ve bu varyasyonun %26'sını açıkladığını gösterdi (R^2 = 26). Medeni durum, sosyal aktivite ve benlik saygısı değişkenleri toplu olarak yalnızlık düzeyindeki değişimin %23'ünü açıkladı.

Sonuç: Evde bakım hizmeti alan yaşlı bireyler arasında benlik saygısının orta düzeyde olduğu, bekar yaşlı bireylerin yalnızlık düzeylerinin evlilere göre daha yüksek olduğu, sosyal olarak aktif olan yaşlı bireylerin yalnızlık düzeylerinin daha düşük olduğu belirlendi. Benlik saygısı arttıkça yalnızlık düzeyinin azaldığı tespit edildi. Özellikle yaş, cinsiyet, eğitim durumu ve kronik hastalıklar gibi değişkenlerin yaşlılarda yalnızlık düzeyleri üzerinde anlamlı bir etkisi olmadığı görüldü. Bu sonuçlar doğrultusunda, evde bakım hizmeti alan yaşlı bireylerin yalnızlık düzeylerinin azaltılması için sosyal aktivitelere katılımlarının ve benlik saygısının ele alınmasının önemi vurgulanmaktadır.

Anahtar Kelimeler: Halk sağlığı, sosyal izolasyon, yalnızlık, yaşlılık

Geliş tarihi / Received: 02.05.2024 Kabul tarihi / Accepted: 11.09.2024

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Alagöz E.Yanık V. ***Factors Affecting The Level of Loneliness Among Elderly Receiving Home Care Services.*** *TJFMPC, 2024; 18 (4):456-465*

DOI: 10.21763/tjfmpc.1477431

Introduction

Elderly individuals experience various difficulties due to their age and emerging diseases. In this context, home care services provided for elderly people today can be identified as a service model developed to help people who can no longer take care of themselves due to their age or illness. These services may include cleaning, meal preparation and delivery, medication reminders, companionship, and transportation.[1,2]

According to the 2023 data from the Turkish Statistical Institute (TUIK), the proportion of elderly individuals aged 65 and over in Turkey is 10.2%. The percentage of the elderly population aged 65 and over who require home care support is 12.3%, while 8.3% of the elderly population aged 65 and over received home care support in the last year.[3] Home care services provided by municipalities primarily aim to reach individuals who are disabled, elderly, bedridden, or dependent on others for their daily activities, whether they live alone or with their families. Patients who require wound care, catheterization, ongoing treatment through injections, intravenous therapy, chronic disease management, terminally ill care, those discharged from the hospital but still needing home treatment, and those in need of home physiotherapy or psychological counseling can benefit from these services. Individuals who meet the specified criteria can apply by filling out application forms on the municipalities' websites and submitting the required documents.[4] The home care service team may include a physician or specialist, nurse, midwife, public health technician, health officer, home care technician, elderly care technician, psychologist, social worker, physiotherapist, pharmacist, dietitian, driver, and other professionals as required by the home health service. The home care services provided by municipalities include doctor consultations, pharmacy and medical supplies services, nursing care, nursing follow-up, physiotherapy, psychological counseling, personal care, household cleaning, hospital services, and companionship services.[5]

Home care services are typically provided by municipal teams and are aimed at supporting elderly individuals in their daily living activities. These services include cleaning, meal preparation and delivery, medication reminders, companionship, and transportation. In contrast, the home health services provided by the Ministry of Health are a model of healthcare that focuses on medical care, treatment, rehabilitation, and addressing the medical needs of patients.[6] The main difference between these two service models is that home care services primarily focus on providing social and daily living support, whereas home health services encompass medical and rehabilitative interventions.[7] The literature discusses how these two service models impact the quality of life of elderly individuals and in which situations each service model should be preferred.[8]

One of the important psycho-social challenges of old age is loneliness. Loneliness can be defined as the feeling of being alone, lacking companionship and intimacy, or having social isolation. The degree of this feeling can range from mild to severe, depending on the person's situation and circumstances. While some people do not feel lonely at all, others may feel very isolated and disconnected from other people.[9]

Individuals' level of loneliness is affected by several factors. One of the most important factors is age. As individuals get older, they are more likely to feel lonely. This is because as they get older, they tend to lose friends and family members due to death and relocation, resulting in fewer people around to connect with.[10]

Physiological changes occurring in old age, the end of work life, the death of spouses, role changes, financial losses, and similar situations make it difficult for individuals to accept themselves. This can lead to difficulties in forming social relationships, a feeling of withdrawal, and a decrease in self-esteem. As a result, elderly people's communication with the environment deteriorates and the feeling of loneliness becomes more intense.[11,12,13]

Primary care and family medicine play a crucial role in addressing the health and well-being of the elderly population. As the first point of contact in the healthcare system, primary care providers are often responsible for coordinating comprehensive care, including the management of chronic diseases, prevention of health deterioration, and addressing psychosocial issues such as loneliness. Understanding the factors that contribute to loneliness among elderly individuals receiving home care services is essential for family physicians and primary care providers. This knowledge enables them to develop more effective interventions, improve patient outcomes, and enhance the overall quality of life for this vulnerable population.

Our research aimed to determine the factors affecting the loneliness levels of the elderly receiving home care services.

Material and Method

Study Design and Sample

This study was planned to determine the factors affecting the level of loneliness among older people aged 65 years and above who receive home care services. It is a cross-sectional descriptive study. The study was conducted between January and May 2023 with elderly individuals aged 65 years and above who receive home care services provided by Beşiktaş Municipality in Istanbul.

The population of the study consisted of older adults receiving home care services from Beşiktaş Municipality in Istanbul. For the sample, the convenience sampling method, one of the non-probability sampling methods, was

used. The elderly who could be reached during the data collection process, who volunteered to participate in the study, and who received home care were included in the sample. In the literature, it is stated that obtaining a sample 10 times the number of items is sufficient in determining the sample size.[14] This study was conducted with 285 elderly individuals who volunteered to participate in the study after the data collection process. Considering the data collection forms used in the study, it was seen that the sample size obtained was sufficient.

Inclusion Criteria:
"Participants included in the study are elderly individuals aged 65 and above who receive home care services, have not been diagnosed with Alzheimer's or dementia, have no communication problems, and are able to read and write in Turkish."

Exclusion Criteria:
"Participants excluded from the study are those diagnosed with Alzheimer's or dementia, those experiencing communication problems, those who leave the study at any stage, and those who provide incomplete or incorrect answers on the data collection forms."

Instruments
The data collection tools included the Personal Information Form, The Loneliness Scale for the Elderly, and the Rosenberg Self-Esteem Scale. Written permission was received from the scale owners via e-mail regarding the use of the scales.
The Personal Information Form: The form consisted of 8 questions prepared by the researchers to determine the demographic characteristics of the participants such as age, gender, and marital status.
The Loneliness Scale for the Elderly (LSE): The measurement tool developed by Gierveld and Kamphuis (1985) to assess the feeling of loneliness was revised by Tilburg and Gierveld (1999), and adapted to Turkish culture by Akgül and Yeşilyaprak.[15] The scale is based on a cognitive-behavioral approach. It has 11 items in total and consists of two subdimensions. Six items (2, 3, 5, 6, 9, 10) of the scale are negative items measuring emotional loneliness, and five items (1, 4, 7, 8, 11) are positive items measuring social loneliness. To calculate total loneliness, emotional loneliness and social loneliness results should be summed. The sum of these two dimensions constitutes the overall loneliness score.[16] The extent of the individual's experience for each statement in the scale is determined by a 3-point Likert-type rating. The three-point rating is as follows; 0=yes, 1=maybe, 2=no. The scale is answered by marking the option that best expresses the person. Six of the scale items were original and five were reverse coded. Items with positive statements (1, 4, 7, 8, 11) are scored as 0=yes, 1=maybe, 2=no; items with negative statements (2, 3, 5, 6, 9, 10) are scored as 2=yes, 1=maybe, 0=no. The lowest score to be obtained from the scale is 0 while the highest score is 22. In the adaptation study conducted by Akgül and Yeşilyaprak[15], the variance explained by the scale was found to be 64.75. In the adaptation study, Cronbach's α reliability coefficient of the scale was calculated as .79 for emotional loneliness, .81 for social loneliness, and .85 for the overall scale.

The Rosenberg Self-Esteem Scale: Scale was adapted to Turkish culture by Çuhadaroğlu.[17] Rosenberg emphasizes the importance of self-evaluation in the concept of self-esteem. The questions in the scale are oriented towards this theme. The Rosenberg Self-Esteem Scale consists of twelve subscales formed with multiple-choice questions. These are Self-Esteem, Self-Concept Continuity, Trusting People, Sensitivity to Criticism, Depressive Affection, Imagination, Psychosomatic Symptoms, Feeling Threatened in Interpersonal Relations, Participation in Debates, Parental Interest, Relationship with the Father, and Psychic Isolation. In this study, the Self-Esteem subscale was used. There are ten items in the Self-Esteem Subscale. According to the evaluation system within the scale, subjects receive a score between 0 and 6. In comparisons made with numerical measurements, self-esteem is evaluated as high (0-1), moderate (2-4), and low (5-6).[18] Therefore, it can be said that individuals with low Self-Esteem Scale scores have a high level of self-esteem, while those with high scores have a lower level of self-esteem.

The score values of the items are explained below.

Measures
The data of the study were collected by face-to-face interview method in the homes of individuals aged 65 years and above who receive home care services from Besiktas Municipality. The average response time was approximately 15 minutes.
Analytic Strategy
The data of the study were analyzed using the SPSS 26 (Statistical Package for Social Science) package program (firma ve ülke adı eklenmeli). AMOS 23 program was preferred for the construct validity of the measurement tools. Skewness and kurtosis values were examined to determine whether the data were normally distributed, and ± 1.5

was taken into consideration to prove normal distribution. Descriptive statistics such as number, percentage, mean, standard deviation, and minimum-maximum values were used in data analysis. Path analysis, one of the structural equation modeling approaches, was used to analyze the relationships between variables. Cronbach's alpha (Cronbach α) values were analyzed to test the reliability levels of the measurement tools used in the study. $p< .05$ was accepted as statistically significant.

Results

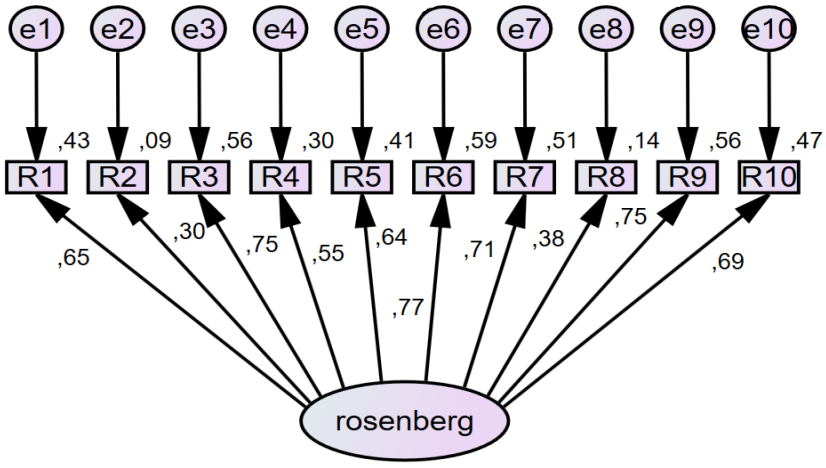
Of the sample, 61.1% consisted of women and more than half (59.3%) were married. When the education level was analyzed, it was seen that most of the participants (41.1%) were primary school graduates, 31.2% were secondary school graduates, and 27.7% had higher education diploma. 75.8% of the elderly receiving home care services had at least one chronic disease. It was determined that 91.2% of the older adults did not receive any social support. 38.6% of elderly individuals engaged in various social activities, but this rate was in the minority compared to those who did not. The average age of the elderly individuals in the sample is 74.3 ± 7.5 years.

The data collection tools in the study, The Rosenberg Self-Esteem Scale and the Loneliness Scale for the Elderly, and the normal distribution of the subdimensions of these scales were evaluated through kurtosis and skewness values. According to the findings obtained, it was observed that the data were normally distributed in both scales and their subscales.

The reliability of the measurement tools was determined by calculating Cronbach's α. For research scales, Cronbach's α value lower than .60 is considered to be unacceptable, between .60 and .65 is undesirable, between .65 and .70 is minimally acceptable, between .70 and .80 is respectable, between .80 and .90 is interpreted to be very good, and if it is much above .90, it is suggested that the researcher should consider shortening the scale.[19] In this study, the Cronbach's α value for the Rosenberg Self-Esteem Scale was found to be .85. The reliability value for the Loneliness Scale for the Elderly was .88 while it was calculated as .80 for the emotional loneliness subdimension and .86 for the social loneliness subdimension.

The "Rosenberg Self-Esteem Scale" scores of the sample ranged between .33 and 2.67 and the mean sample was found to be 1.365 ± 0.392. This score indicates a moderate level of self-esteem.

The mean score of the Loneliness Scale for the Elderly, the other measurement tool of the study, was 9.723 ± 6.657 points, while the emotional loneliness subdimension mean score was found to be 6.140 ± 3.697 points and the social loneliness subdimension mean score was 3.583 ± 1.654 points.



CMIN=74,472;DF=33;CMIN/DF=2,257;p=,000;RMSEA=,067;CFI=,963;GFI=,951;AGFI=,918;NFI=,936

Figure 1.

AGFI: Adjustment Goodness of Fit Index; CFI: Comparative Fit Index; GFI: Goodness of Fit Index; RMSEA: Root Mean Square Error of Approximation; NFI: Normed Fit Index

Diagram 1. The Validity Results of the Rosenberg Self-Esteem Scale

The model fit of the Rosenberg Self-Esteem Scale, which consists of a single dimension and 10 items, was tested with level I multi-factor CFA. Since the data were normally distributed, the maximum likelihood estimation method was used.

When the goodness-of-fit values of the scale were examined, $\chi 2$ /df= 2.26, AGFI= .92, CFI = .96, GFI = .55, RMSA= .07, NFI= .94 values were found. The obtained goodness-of-fit values were within acceptable limits[20-23] In line with these results, it was concluded that the goodness-of-fit values were at the desired level, validating the original version of the scale and providing evidence for the construct validity in this study.

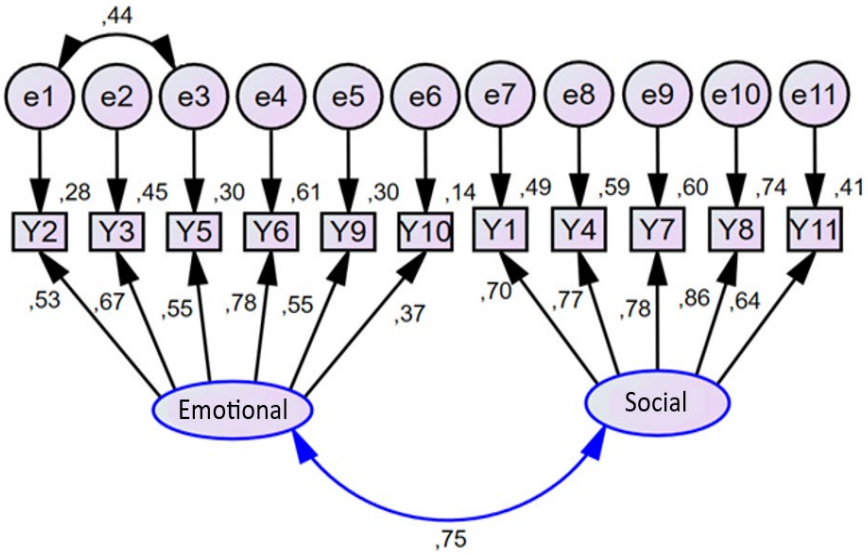


Figure 2.

AGFI: Adjustment Goodness of Fit Index; CFI: Comparative Fit Index; GFI: Goodness of Fit Index; RMSEA: Root Mean Square Error of Approximation; NFI: Normed Fit Index

Diagram 2. The Loneliness Scale Validity Results

The Loneliness Scale for the Elderly consisting of 2 dimensions and 11 items was tested with model fitting. Since the data were normally distributed, the maximum likelihood estimation was used. When the correction indices of the model were examined, it was seen that the covariance of Y2-Y5 items was high and the error terms of these items were combined.

When the goodness-of-fit values of the scale were examined, values of $\chi 2$ /df= 2.650, AGFI= .90, CFI = .95, GFI = .94, RMSA= .07, NFI= .93 were found. The obtained goodness-of-fit values were within acceptable limits. [20-23] These findings showed that the goodness-of-fit values were at the desired level, thus the original version of the scale was validated and its construct validity was provided for this study.

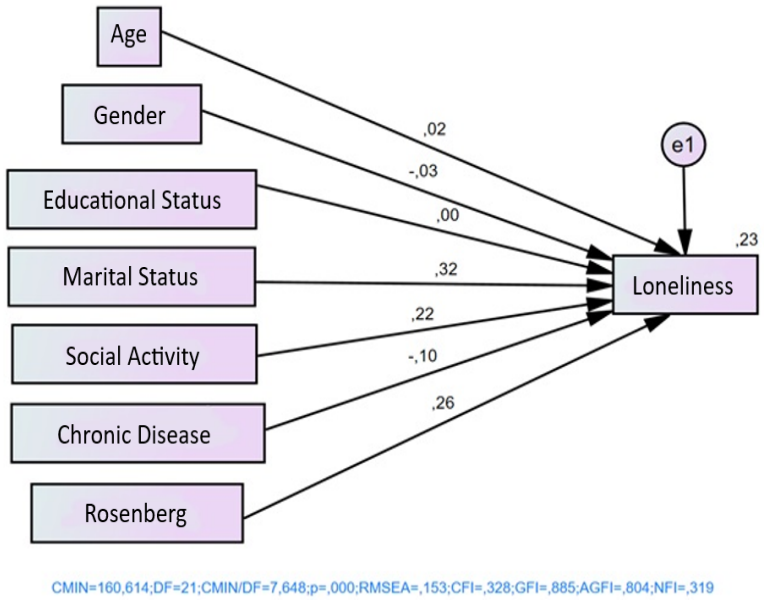


Figure 3.

Diagram 3. The Initial Model Estimating Factors That Affect Loneliness

To estimate the factors affecting the loneliness levels of elderly individuals receiving home care services, an initial structural model was established and the goodness-of-fit values of this model were examined. Variables such as age (scale), gender (female:1; male:2), marital status (married:1; single:2), educational status (primary education:1; secondary education:2; higher education:3), social activity (present:1; absent:2), chronic disease (yes:1; no:2) and Rosenberg Self-Esteem Scale were included in the model. When the goodness-of-fit values of the model were examined, it was seen that the values did not meet the minimum goodness-of-fit value required for a valid model (*χ2 /df =7.648, NFI= 0.32, CFI=0.33, GFI= 0.86, AGFI= 0.80, RMSEA= 0.15).* Therefore, t values and significance levels of the variables in the model were analyzed.

Table 1. *Significance Levels of the Initial Model Estimating the Level of Loneliness*

Observed Variable	Implicit Variable Structure	t	Significance
Age	Loneliness	.367	.714
Gender	Loneliness	-.433	.665
Marital Status	Loneliness	5.584	.000
Educational Status	Loneliness	.006	.996
Social Activity	Loneliness	3.824	.000
Chronic Disease	Loneliness	-1.902	.057
Rosenberg	Loneliness	4.913	.000

When the significance of the contribution of the variables included in the initial estimation model was examined, a significant relationship was found between marital status (t=5.584, p<.000), social activity (t=3.824, p<.000), Rosenberg Self-Esteem (t=4.913, p<.000) variables and the model. On the other hand, it was found that the age, gender, educational status, and presence of chronic disease variables did not contribute sufficiently to the model (p>.05) and therefore they were removed and a new model was established.

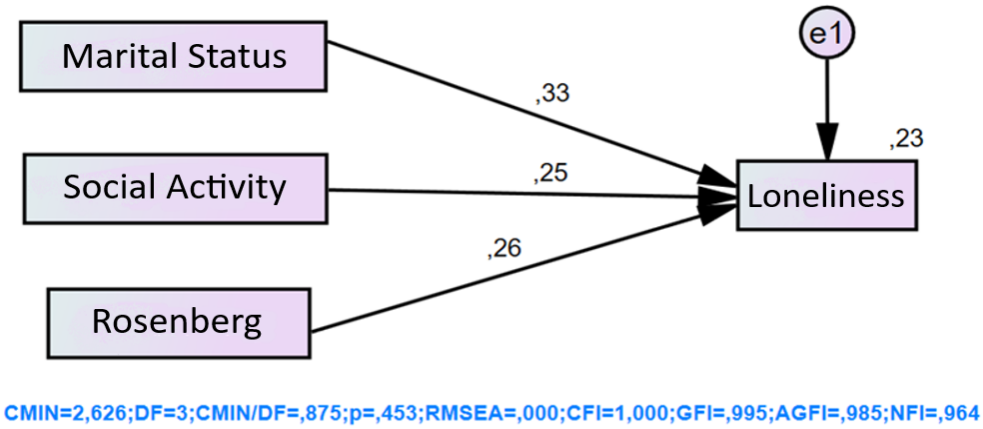


Figure 4.

Diagram 4. The Revised Model Estimating Factors That Affect Loneliness

To estimate the factors affecting the level of loneliness among older adults receiving home care services, an initial structural model was established, but since the goodness-of-fit values of the model were not at the desired level, a new model was established by removing the variables that did not contribute significantly to the model. Marital status, social activity, and Rosenberg Self-Esteem variables that contributed significantly to the initial model were included in this model. When the goodness-of-fit values of the model were examined, it was determined that the minimum goodness-of-fit values required for a valid model were obtained (*χ2 /df =.875, NFI= 0.96, CFI=.98, GFI= 1.00, AGFI= 0.995, RMSEA= 0.00).*

Table 2. *Significance Levels of the Revised Model Estimating the Level of Loneliness*

Variable	Variable	t	Significance
Marital Status	Loneliness	6.261	.000
Social Activity	Loneliness	4.741	.000
Rosenberg	Loneliness	4.903	.000

When the significance of the contribution of the variables included in the revised model was examined, it was determined that marital status (t=6.262, <.001), social activity (t=4.741, p<0.001), and Rosenberg Self-Esteem (t=4.903; p<.001) variables showed a significant relationship with the model. In addition, the goodness-of-fit values of the revised model as a whole were at an acceptable level. Based on these results, the revised model was accepted as it is.

According to the model obtained, the loneliness level of single elderly was higher than married ones, and being single explained 33% of the variation in loneliness level (R^2 =33). The other variable that had a significant contribution to the model was the social activity variable. The loneliness levels of older people who were involved in social activities were found to be lower than those who were not. Social activity variable can explain 25% of the variation in the level of loneliness (R^2 =25). Another important variable was self-esteem (The Rosenberg Self-Esteem Scale). As the self-esteem of elderly individuals increased, their loneliness levels decreased. 26% of the variation in loneliness level (R^2 =26) can be explained by the self-esteem variable. Marital status, social activity, and self-esteem variables, which significantly contributed to the model, together explained 23% of the variation in loneliness level.

Discussion

With aging, experiencing the loss of a spouse, slowing down of productivity, loss of energy or reluctance to engage in social activities have been identified to increase feelings of loneliness. It is observed that elderly individuals with decreased productivity and limited future expectations experience a decrease in self-esteem, which consequently affects loneliness.

As the self-esteem of older adults increases, their loneliness levels decrease.

In our study, it was found that as the self-esteem of elderly individuals increased, their loneliness levels decreased. In addition, the self-esteem levels of the older people receiving home care services were found to be moderate. In the study conducted by Yılmaz (2017) with the elderly staying in a nursing home, it was established that the majority of them had moderate levels of self-esteem.[24] In the study by Alçelik (2013) carried out with 140 people aged between 57-91, the mean self-esteem score was found to be moderate. The study showed that the mean self-esteem scores according to age groups were very close to each other and there was no significant difference.[25] In the study conducted by Çelik et al. (2017), it was determined that the level of loneliness (8.5±4.6) was at an acceptable level.[26] The study of Dahlberg and McKee (2014) with the elderly found that the loneliness score was at a moderate level.[27] In the study carried out by Çalık (2021) with 332 older people, it was established that the loneliness score in the elderly was moderate, they had a positive self-schema and their self-esteem was high.[28] It is believed that as the self-worth of individuals increases, they find the power to eliminate the factors that cause them to feel lonely. Therefore, it is thought that as self-esteem increases, the level of loneliness will decrease.

The loneliness level of the single elderly is higher than the married ones.

In our study, loneliness levels of single elderly were found to be higher than married individuals. Ceyhan[29] found a significant difference in loneliness mean scores among older adults based on their marital status, and it was determined that widowed individuals had higher loneliness mean scores compared to married ones. The results obtained from Ozvurmaz's (2018) study showed that there was a significant difference between the mean scores of married and single elderly individuals, and singles had higher loneliness scores than married ones.[30] In the study carried out by Polat and Geçici (2020), loneliness was found to be significantly higher in older adults who were single and lived alone.[31] In the study of Ağırman and Gençer (2017), when loneliness levels were compared, the highest sense of loneliness was observed in elderly individuals living alone, followed by those residing in nursing homes, and lastly, in elderly individuals living with their families.[32] In the study conducted by Neto (2014) with 1154 participants evaluating the relationship between the level of loneliness and marital status of the individuals, it was found that single participants showed a higher level of loneliness than married ones. In this context, the results showed that there was a significant positive relationship between the loneliness level and marital status.[1] In the literature review, in parallel with our study, it was found that the loneliness level of singles was higher.[33-37] The reason for this may be that single elderly may experience intense loneliness after the death of their spouse they

were married to for many years. Older people who have never been married may feel lonely because they feel that they have reached the end of their lives and there is no one to support them in their last days.

Elderly people who engage in social activities have lower levels of loneliness than those who do not.

According to the results of the study, the loneliness levels of the elderly who were involved in social activities were lower. Polat & Kahraman (2013) stated that over time, there is a decrease in the social activities of elderly individuals, leading to concerns about not being able to return to their former lives, a sense of inadequacy, and the emergence of loneliness.[38] The study results of Singh and Misra (2009) proved that there was a negative relationship between the level of loneliness and social activity.[39] In the study conducted by Dereli et al. (2010) with a sample of 48 elderly people, it was determined that older adults who did not participate in group activities in the nursing home experienced more intense loneliness than those who did. In the same study, it was established that the elderly who did not participate in individual activities felt lonelier than those who did.[40] Çalık (2021) found that the social loneliness score of the elderly differed according to their participation in social activities. In addition, it was determined that the social loneliness of the elderly who never participated in activities, had no relatives, could not go out, were satisfied with food and rehabilitation services, and were satisfied with the physical conditions of the nursing home was higher.[28] With old age, there may be a decrease in the level of social activity due to the presence of chronic diseases, loss of energy, and a decline in the areas where they can engage in social activities. With the reduction of social activities, elderly individuals may experience a more intense sense of loneliness for being inadequate in society, shifting from a productive role to a consumer role and moving away from their old roles.

4.1 Limitations

The results of this study are limited to the sample and the measurement tools used in the study.

Conclusion

According to the findings of this study, which was conducted to determine the factors affecting the loneliness levels of elderly individuals receiving home care services, the following results were obtained.

- The level of self-esteem among the elderly receiving home care services was moderate.
- The loneliness level of the single elderly was higher than the married ones.
- Elderly people who engaged in social activities had lower levels of loneliness than those who did not.
- As the self-esteem of elderly individuals increased, their loneliness levels decreased.
- The variables of age, gender, educational status, and presence of chronic diseases did not affect the loneliness level of the elderly.

Recommendations

Within the scope of the study, planning educational and cultural excursion programs to reduce the level of loneliness among the elderly, and organizing social activities to increase their motivation levels are necessary.

It may be recommended that older individuals should be cared for with a holistic approach. Especially those residing in institutions, experiencing financial difficulties, unable to establish social relationships, who lost their spouses, and who are at risk for loneliness, should be monitored regularly. Treatment care programs should be established by health professionals and the elderly at risk should be evaluated within the scope of community mental health.

Ethical Approval

Ethics committee approval was obtained from the Istanbul Arel University Ethics Committee to evaluate the ethical appropriateness of the study (Date and No: December 30,2022/26). In addition, written and verbal informed consent was obtained from individuals who agreed to participate in the study.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding Sources

This research did not receive any specific grants from funding agencies in the public, commercial or not-for-profit sectors.

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