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EMOTIONAL POVERTY OF OLDER PERSONS IN RESIDENTIAL FACILITIES IN THE WESTERN CAPE PROVINCE OF SOUTH AFRICA

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ABSTRACT

Older persons are often referred to as a forgotten generation even as the population is rapidly ageing worldwide. According to the World Health Organization, it is estimated that by 2030 one in every eight people will be over 65. A number of older persons regularly move to residential facilities owing to unforeseen circumstances such as deteriorating health. This study was conducted to explore the concept of the emotional poverty of older persons in residential facilities in the Western Cape province of South Africa. A qualitative approach was followed which was descriptive and explorative in nature. Purposive sampling was used to recruit and involve participants. Interviews were conducted with 20 older persons and 10 social workers. Data were verified by ensuring the credibility, authenticity, dependability and transferability of the study. The data were analysed and sorted into themes and sub-themes, with relevant narratives underpinning the themes and sub-themes. Findings of the study indicated that older persons in residential facilities often experience loneliness, depression and limited contact with the outside world, resulting in emotional poverty. Recommendations of the study include improved service rendering to reduce the emotional poverty of older persons.

Keywords: emotional poverty; feelings of depression; isolation; loneliness; older persons; residential facility; social work

INTRODUCTION

Recent statistics indicate that the world population is ageing rapidly, and that the age group over 60 needs increasing support and attention (Roos et al., 2023; World Health Organization, 2021). Most countries face vast challenges to ensure that their health and social systems are adequate to cater to the needs of an ever-growing ageing population. Provision must be made for medical care and support on all levels, including functional, emotional and social support. Davison et al. (2019) identified persons of 60 years and above as a vulnerable group in society, especially those in residential facilities. These individuals can be exceptionally lonely, not only in a time of crisis such as the Covid-19 pandemic, but also in general when people often feel excluded from the outside world (Smith et al., 2020). A possible fall-out of such feelings of isolation and loneliness is emotional poverty, a phenomenon which is on the rise. Kleinspehn-Ammerlahn et al. (2008) and Scherger et al. (2011) are of the opinion that as a result of numerous factors such as a decline in health and mobility, older persons in residential facilities could be deprived of positive stimuli, leading to emotional poverty (Bigby et al., 2011; Silva & Boemer, 2009). According to the Older Persons Act 13 of 2006 (Republic of South Africa [RSA], 2006), a residential facility is a building, or a structure used primarily for the purpose of providing accommodation and care for older persons. Emotional poverty should not be seen in isolation because several factors could be contributing to the emotional poverty. This study focused specifically on the phenomenon of emotional poverty, how it affects older persons in residential facilities, how it can be identified. The study indicates possible ways to resolve this by especially social workers and other members of a multi-disciplinary team. Therefore, the goal of this study was to enhance an understanding of the emotional poverty of older persons in residential facilities.

BACKGROUND OF THE STUDY

To fully conceptualise emotional poverty, it is important to understand that, in general, poverty is the scarcity or the lack of a certain amount of material possessions or money, according to the United Nations Educational, Scientific and Cultural Organisation (UNESCO, 2019). Poverty could also be seen as a multilayered concept that indicates the lack of resources required to meet a person's basic needs such as for food, clothing, shelter and meaningful relationships. It is significant that the emotional dimension of poverty is often overlooked. For this study, emotional poverty is described as a condition in which an older person lacks the basic requirements for a minimum standard of wellbeing, including biological, psychological and social aspects, with a specific focus on the implications for social wellbeing. Social isolation, loneliness, feelings of depression and minimal or no contact with the outside world all point to emotional poverty. Borrico and Arias (2018) identified that especially a lack of support and love could result in emotional poverty. Social workers who do gerontological social work focus on enabling older persons to live active, healthy and independent lives for as long as possible in an attempt to reduce emotional poverty (Lee et al., 2016).

Literature searches revealed that research on emotional poverty amongst older persons in residential facilities is scarce (Jurblum et al., 2020; Powell & Orme, 2011; Soulières & Charpentier, 2022). Phaswana-Mafuya and Peltzer (2017) found that amongst South African adults participating in the Study of Global Ageing and Adult Health, loneliness has been estimated to affect between 9.9% and 12.5% of those over 70. This study thus further explores the phenomenon of loneliness which Phaswana-Mafuya and Peltzer (2017) identified and fills an important gap, which is to gain more insight into the phenomenon of emotional poverty among older persons in residential facilities in South Africa, as well as making significant recommendations. Emotional poverty was explored and described through the voices of older persons in residential facilities as well as social workers delivering services to them. This study also addresses the recommendation of Geyer et al. (2023) that future research should focus on South African older persons in residential care. Their observations on loneliness and the gerontological social work service that may be required are context-specific and unique and may differ from those living in a community.

EMOTIONAL POVERTY – A MODERN WORLDWIDE PHENOMENON

Gray and Worlledge (2016), Perlman and Peplau (1998) as well as Van Beljouw et al. (2014) identified loneliness, feelings of depression and social isolation as the main indicators of emotional poverty.

Loneliness is a very individual experience and there are different views on the nature of loneliness. Loneliness can be described as an individual perception of little or no contact with other people (Dahlberg et al., 2022). Loneliness can be linked with premature mortality (HM Government, 2018; Perlman & Peplau, 1998; Van Beljouw et al., 2014), physical and mental ill-health (Gray & Worlledge, 2016), declining cognitive function and expanded use of health services (Amzat & Jayawardena, 2016). Buecker et al. (2020) also view loneliness as including a misalignment between a person's desired and actual relationships. In other words, it could be a longing for relationships that are absent.

According to Landman and Rohman (2022), loneliness can be viewed as a three-dimensional structure differentiating between emotional loneliness (perceived lack of emotional connection with another), social loneliness (perceived lack of a broader social network) and physical loneliness (perceived lack of physical contact). It is significant to recognise that people can also feel lonely in a crowd, as older people could, for instance, also experience loneliness in a large residential facility. A person could still feel connected while physically alone; for example, older persons whose children have emigrated, but with whom they still have regular telephonic contact, could still find meaning and significance in their lives (Luchetti et al., 2020; Pengpid & Peltzer, 2024). To be alone thus does not in itself make a person lonely, but loneliness is rather the perception of being alone. Tiwari (2013) is of the opinion that people with low self-esteem and less self-worth exhibit greater loneliness than those whose self-esteem and sense of self-worth are higher.

Ageing may add other challenges that can contribute to a solitary life and emotional poverty. Loss of a life partner, friends and family, disability or moving house are all examples of such challenges. Other risk factors for emotional poverty include changes in mobility, physical health and cognitive decline as well as advancing age that increases the risk of sensory impairment. These impairments can make attempts at communication, transportation and socialising more challenging (Gentry & Palmer, 2021). Tiwari's (2013) thoughts on loneliness have been confirmed by the later findings of scholars that loneliness can be so serious that it can be referred to as pathological loneliness. Loneliness on this level is a clear-cut contributor to emotional poverty.

Feelings of depression can be a second indicator of emotional poverty. Depression is one of the most common mental health issues that older people experience (Edwards et al., 2023; Jack et al., 2014). Despite the strong correlation between loneliness and depression, they are distinct phenomena. Loneliness is typically defined in relation to discrepancies between actual and desired social contact (Perlman & Peplau, 1998), whereas depression refers to a more wide-ranging mood disorder (McHugh et al., 2020). Depression can be described as a mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure lasting two or more weeks, according to Von Faber et al. (2016). Bernard (2018) also defines depression as a disease with decayed mood as its main symptomatology. There are also feelings of hurt, ill humour, anguish and panic attacks, performance decay of various psychic and cognitive functions, tendency to isolation, demotivation, apathy, abulia, difficulty to enjoy, hopelessness, motor inhibition, hypotonia and negative thoughts, including possible delusions in serious cases. According to the DSM-V, older persons who display two or more core symptoms for at least two weeks may be diagnosed with clinical depression (American Psychiatric Association, 2022). These symptoms are feelings of worthlessness, guilt, difficulty to concentrate and make decisions, impaired concentration, agitation, insomnia and hypersomnia, change in weight and recurrent thoughts of death or suicide ideation (American Psychiatric Association, 2022; Blazer, 2003).

Loneliness and depression are often intertwined in a vicious cycle, with continuous loneliness possibly resulting in despondency, and ultimately in depression (Cacioppo et al., 2014; Cohen-Mansfield et al., 2016; Nwakasi et al., 2021). Research on depression in older persons in residential facilities is scarce. Just moving to a residential facility is often a significant challenge for an older person. Queirós et al. (2021) are of the opinion that as soon as older persons enter a residential facility, any sign of depression needs to be identified and treated rapidly. It would be extremely helpful if these services are available to help them to adapt optimally throughout their transition period. These scholars (Queirós et al., 2021:41) add that "by its very nature, depression is an insidious psychiatric disease, and, in a long-term care setting, it can become part of a vicious circle". Furthermore, they explain that the permutations of distance and isolation from the life older persons used to have, together with now having to adapt to living in a residential facility or even sharing a room, can challenge their resilience and capacity to deal with change. Kelchner (2002) adds that older people in residential facilities often experience loneliness, helplessness and boredom.

Social isolation is a third indicator of emotional poverty. Both loneliness and social isolation refer to a lack of social connection. However, these two concepts also differ from each other. Loneliness can be a negative, subjective experience, while social isolation could be regarded as more objective and refers to the absence of relationships or ties with other people (De Jong-Gierveld et al., 2015; Dykstra, 2009; Taylor, 2020; Teater et al., 2021). Cohen-Mansfield et al. (2016) explain that loneliness can be contrasted with a sense of belonging, whereas social isolation contrasts with social participation. Cohen-Mansfield and Perach (2015) define social isolation as having minimal or no contact with other people or with specific others. Taylor (2020) adds that a lack of strong and supportive social networks could result in social isolation. The above-mentioned scholars (Cohen-Mansfield & Perach, 2015; Taylor, 2020) all point out that studies focusing only on social isolation are rare, which is why the three indicators of emotional poverty which have been discussed so far are intertwined, and all three should be taken into consideration in addressing emotional poverty.

Taylor (2020) explored how social isolation in linked to loneliness amongst older adults. He found that maladaptive cognitions and behaviours can intensify social isolation in two distinctive ways: (1) it can cause older persons who are already lonely to become even more disengaged from friends and family members; or (2) it can cause their families and friends to disengage more from them. This study also indicated that if loneliness is perpetuated, older persons' feelings of having poor connections or no connection with friends and family could become their objective reality. This objective reality could have a direct bearing on the emotional poverty of older persons. It is thus important for service providers who render services to older persons in residential facilities to acknowledge the reality of emotional poverty and develop appropriate interventions to combat it.

RESEARCH METHODOLOGY

The study followed a qualitative approach, explorative and descriptive in nature. The explorative part of the study focused on aspects that could contribute to emotional poverty as well as focusing on the role of social workers who do gerontological social work. Details of the findings captured the descriptive nature of the study (Nieuwenhuis, 2020). A research design is an essential component of qualitative research and for the purpose of this study a combination of exploratory and descriptive designs was used. The intention of this study was to explore aspects that could contribute to emotional poverty. A descriptive design was used to detail the findings and provide guidelines for older people in residential facilities who experience emotional poverty as well as social workers rendering services to them. Furthermore, the general approach entailed shifting between inductive (research moving from the particular to the general) and deductive (research moving from general to specific) reasoning. Two groups of participants took part in this study, namely older persons in residential facilities and social workers who do gerontological social work. This combination led to the generation of thick and vivid descriptions of emotional poverty in older persons in residential facilities (Creswell & Creswell, 2018; Schurink et al., 2021).

This qualitative research study was conducted in two phases. Phase 1 consisted of face-to-face interviews with group 1, consisting of the older persons living in residential facilities. Twenty participants from four different residential facilities in the Western Cape, South Africa, were interviewed in this group. Two of the residential facilities are public institutions and receive a state subsidy, while the other two residential facilities are semi-private but are granted a minimal subsidy. After this, phase 2 was implemented where 10 social workers who do gerontological social work were interviewed. Purposive sampling was followed to recruit and involve all the participants (Strydom & Roestenberg, 2021). Creswell and Poth (2018) argued that since qualitative research focuses on a deep, holistic understanding of a phenomenon, transferability is of greater importance to the researcher than generalisability. Transferability is the degree to which the results of qualitative research can be transferred to other contexts or backgrounds with other respondents. Data saturation was reached after the 12th interview conducted with group 1 and the 6th interview with group 2. At this point, further interviews were conducted with both groups to ensure that if any new data were obtained, that would also be captured to ensure a thick description of data. It was clear at the end of the data-collection phase that by utilising these two groups, a broad understanding and knowledge of emotional poverty was gained. The main inclusion criteria for group 1 were that participants had to be 65 years and older, residing in a residential facility and not diagnosed as living with dementia. In South Africa, according to the Older Persons Act 13 of 2006 (RSA, 2006), an older person in the case of men is one over 65 years and in the case of women over 60 years old. For group 2, inclusion criteria were that participants needed to be registered with the South African Council for Social Service Profession (SACSSP) and actively rendering services to older persons in residential facilities.

Data analysis was done according to the steps specified by Schurink et al. (2021). Step 1 entails planning for recording of data. After a pilot study was successfully completed, semi-structured in-depth interviews were conducted. Such interviews are ideal to understand participants' lives, experiences, feelings, perceptions or situations from their point of view as expressed in their own words (Nieuwenhuis, 2020). An interview guide was used, including numerous probing questions where necessary. All the interviews with both groups 1 and 2 were recorded on a digital record application on a smartphone. To this end, participants had to give their informed consent. The interview could then be recorded. The date of the interview was also noted. Step 2 consists of data collection and preliminary analysis. In this study, the transcriptions of the interviews were done as soon as possible after the interview, while details of the interviews were still fresh. This was especially beneficial for the identification of the themes. Each interview was typed out verbatim and the process of denaturalisation removed interviewee noise, incorrect grammar and unnecessary stutters for the purposes of obtaining purely informational narratives (MacLean et al., 2004; Oliver et al., 2005). All the transcriptions were done word-for-word (verbatim) without the assistance of a transcription computer program in order to ensure familiarity with and immersion in the data. This was especially beneficial for the identification of themes and sub-themes. Step 3 is about managing the data. In any kind of research, it is crucial that all data collected should be properly organised. All the data were stored online and in a secure folder with a password for access.

Duplicate files of the recordings and transcripts were also stored on an external hard drive which was safely locked in a vault. All the field notes and consent forms were also locked in the vault/safe after use.

Step 4 involves reading and writing of memos where "data immersion" took place (Schurink et al., 2021:404). The next vital step, step 5, involves generating themes, sub-themes and categories. For the purpose of this study, thematic content analysis was utilised. The data were analysed by colour coding the different themes. Each interview was printed because the hard copies were easier and more suitable to analyse and to colour code, which aided the interpretation. Three themes were identified and divided into sub-themes. The data from both the social work participant group and the older person's group were integrated, meaning that the narratives of both groups were used simultaneously under the same themes and sub-themes. This ensured that similarities and differences of opinion between the two groups were identified. Step 6 entails coding of the data which is closely linked with generating themes and sub-themes. Step 7 entails testing emergent understandings. This step emphasises the importance of ongoing evaluation. While the process of identifying themes and sub-themes is ongoing, it is important to evaluate the data for usefulness and relevance. To maintain focus on the aim of the research, thick descriptions were used based on the in-depth interviews to form an idea of what both older persons and social workers had to say.

Data could be verified by ensuring credibility, authenticity, dependability and transferability of the study. Credibility was ensured by member checking, with two participants of each group who read through their transcribed interviews to verify that they were a true reflection of the interview. The two groups utilised during data collection added to the transferability of the study. Dependability of the study was ensured by following and recording a step-by step research approach for the data collection and analysis. The comprehensive transcribed interviews added to the confirmability of the study (Nieuwenhuis, 2020). Ethical issues in social science research are pervasive and complex and are relevant to human interactions and behaviours that are prone to be risky and unpredictable (Strydom & Roestenburg, 2021). Being social workers registered with the South African Council for Social Service Professions (SACSSP), researchers are bound by its ethical code. The research was based on the same principles and rules as stipulated by the ethical code of the SACSSP. Aspects such as voluntary participation, informed consent, prevention of harm and ensuring privacy, anonymity and confidentiality were taken into consideration. Other important principles and values guiding this study were social justice, respect for human rights, worth and dignity, integrity, upholding professional standards and caring about the wellbeing of others. Ethical clearance for this medium-risk study was obtained from Stellenbosch University (Ethical clearance number and Project ID: 23761).

RESEARCH FINDINGS

In group 1 (older persons in residential facilities), 13 of the participants were women and 7 were men. According to the literature (Guralnik et al., 2000), there are substantially more older women

than older men, while Kim and Lee (2022) found that the prevalence of loneliness is higher among older women than among older men. The age of the participants varied between 65 and 96 years. Regarding marital status, 19 of the 20 participants were single (mostly widowed or divorced), which could have an effect on their emotional poverty. As for length of stay, more than 11 of the participants had been staying in residential facilities for more than three years. This meant that where participants indicated loneliness and emotional poverty, it could not be attributed to a recent move but rather pointed to feelings stretching over a longer period. Participants in group 1 are identified by group and participant number, e.g. G1P1 to G1P20.

In group 2 (social workers who do gerontological social work), all 10 participants were female, with more than half of them having more than 20 years of social work experience. Youdin (2014) emphasises that social workers who do gerontological social work require a clear understanding of and insight into older persons' biological, psychological and social needs, including accommodation, knowledge of the types of dementia, death-and-dying issues, and familiarity with different types of care settings that comes only with experience. Participants in group 2 are identified by group and participant number, e.g. G2P1 to G2P10.

THEMES AND SUB-THEMES

Table 1: **Themes and sub-themes of the study**

THEME 1 – FEELINGS OF LONELINESS AND THE DIFFERENT REACTIONS TO THEM	Sub-theme 1.1 Denying having any feelings of loneliness
	Sub-theme 1.2 Believing loneliness is your own fault
	Sub-theme 1.3 The importance of acknowledging feelings of loneliness
THEME 2 – FEELINGS OF DEPRESSION AND HOW THEY MANIFEST	Sub-theme 2.1 Views on what depression is
	Sub-theme 2.2 Different ways of dealing with depression
THEME 3 – SOCIAL ISOLATION	Sub-theme 3.1 Covid-19-related social isolation and its psychosocial effects
	Sub-theme 3.2 Different ways to reduce social isolation.

Theme 1 – Feelings of loneliness and the different reactions to them

The first theme related to emotional poverty deal with feelings of loneliness and how different participants react to such feeling. This theme is divided into three sub-themes as indicated below.

Sub-theme 1.1 Denying having any feelings of loneliness

Atkins et al. (2013) emphasise that programmes directed at improving the mental health and quality of life of older persons are extremely important. The comments from group 1 (below), indicate that some participants did not feel lonely or did not want to admit that they experienced periods of loneliness:

No, I am a quiet person, so loneliness doesn't bother me. I am content with my own company. I can amuse myself. I can take a book, and I read, or I do my knitting. And I ignore them. (G1P2)

But I can't be lonely. I am not the type to be lonely. My father was a sea captain, sat in his cabin for months so we are strong. I am like my father. (G1P6)

No, I don't feel lonely here because I have got friends with whom I can talk. My first day when I arrived, I felt that everything was strange but then someone said that I mustn't sit in my room. Go and talk to the other people. When you sit in your room, you can get sick easily. (G1P8)

No, I have never felt that way. Everybody comes to the dining room and to the TV so there isn't really isolation. (G1P12)

Participants 2 and 6 sound like strong individuals, but it is possible that they didn't want to admit feeling lonely at times, as they presented as being overly confident. This corresponds with research from Buecker et al. (2020), which found that in some situations, describing yourself as someone who is often lonely might mean you are regarded as wrong or weak. In residential facilities for older persons, there might be different social groups and not being part of one can evoke a sense of failure. Usually, a resident will rather deny loneliness than being seen as feeble. Hauge and Kirkevold (2012) conducted an interesting study on loneliness which showed that older persons, who were not lonely, often had pessimistic attitudes towards other older persons who experienced loneliness. The following comment from a participant in group 2 links up with these findings, showing that there could be a stigma attached to acknowledging loneliness:

The stigma of the 'older generation' who didn't grow up with psychologists or psychiatrists. This help can be so valuable to address feelings of loneliness. But what do they say. I am not crazy. Why would I go and see a psychologist. A lot say that to me. They say, no, I am fine. (G2P8)

The above narrative concurs with the study by Goll et al. (2015), which reported that older persons may minimise the problems associated with being lonely.

Sub-theme 1.2 Believing loneliness is your own fault

To further illustrate emotional poverty, this sub-theme highlights the stigma and ignorance still attached to loneliness, especially among older persons in a residential facility. These examples suggest that there is total ignorance about the seriousness of loneliness. Two participants said the following:

Yes, some people are like hermits. They go to the toilet, and they go to bed and repeat the cycle. They live their lives away. They don't even come to the waiting room to talk. They don't need to make something; they can just come and talk but they don't do it. (G1P2)

Man, no, I can't see that people get lonely. It is then your own fault, I think. You mustn't sit and keep everything in. I also don't believe in psychologists at all. Honestly. It can be stopped at an

earlier stage. These people really get out of control. It was their own fault from the beginning. (G1P5)

The two narratives above indicate scant knowledge about of what loneliness is and a very poor understanding of possible causes of feelings of loneliness. It could be that these participants may experience loneliness themselves, also being in residential facilities, but are too proud or scared to admit it, owing to the mistaken idea that people who are lonely are anti-social or mentally unwell. People often deny or reject the notion that they are feeling lonely because they are worried that it would reveal some personal shortcoming. The next comment of a participant from group 2 shows that it can be challenging to address loneliness in an older person who is feeling embittered and not open to accepting support or intervention:

Loneliness is a challenge. Here are people content to sit in their room, with a long face. They come to the dining room with a long face and not necessarily greet anyone. So, they become lonely of their own choice. It is linked to your personality and a lot of people are also embittered. One does not know what happened in their past. (G2P3)

The literature suggests that loneliness increases among people over 80 years of age and that it is most prevalent in the "oldest of the old" referring to individuals aged 80 and over (Pengpid & Peltzer, 2024; Yang & Victor, 2011). This corresponds with the demographics of this study, namely that half of the participants are over the age of 80 years.

Sub-theme 1.3 The importance of acknowledging feelings of loneliness

Sub-theme 1.3 contains comments expressing the opposite of those in the preceding sub-themes, with participants actually admitting to feelings of loneliness:

Yes, I get lonely. I find that most people switch their TVs on. Since not being independent anymore, I can't touch a book. I have one book which I bought before it all started but I still haven't got halfway. (G1P7)

Yes, there are often times where I miss my children, but then I say no, I am wrong, they phone me and do still care. So, I try to put myself at ease. I have not seen anyone yet as they stay overseas. (G1P12)

The older persons quoted above try to work on their loneliness and try to acknowledge feeling lonely. Gray and Worlledge (2016) mentioned that loneliness may arise from a person's social network being too small, or because the network, although large, does not satisfy the individual's specific needs. Loneliness becomes an issue of serious concern when it becomes internalised long enough to create a constant, self-reinforcing circle of negative views, feelings and behaviours (Cacioppo & Patrick, 2008).

Some participants indicated that they try to create meaning from their loneliness by turning to God for answers and comfort, believing that it is all part of God's plan. It is significant that Parada

(2022) found that spirituality remains an ongoing source of support and comfort for many older persons when their health, social and financial resources are declining.

> *Yes, there are many times when I feel sad and lonely and then I lie on my bed. And then I pray. I ask the Lord to take it away from me and He then takes it away … If you go away from your house and they put you here, then you feel sad. You miss people and you feel sad.* (G1P10)

> *I am very alone here. My family doesn't want to come and nobody. Oh…but what can I do. Yes, sometimes I feel lonely and need someone to talk to … I sit in the chapel and read and learn about Jesus. I don't have friends here … Yes, I am alone, but I trust God.* (G1P15)

Tusasiirwe et al. (2023) are of the opinion that a spiritual outlook could prevent loneliness from turning into depression and motivate a depressed older person to initiate social interactions, thereby decreasing loneliness. Social workers should consider their clients' spiritual background as potential strengths that might enhance their resilience against depression. When older persons experience feelings of despair, negative feelings might escalate into possible depression as well as emotional poverty.

> *Yes, you get lonely. Something upset me the other day and I just wanted to cry, and I did cry. I was tearful the whole day, so it was probably loneliness … You almost feel that you can do everything you want to get off the edge of the planet. You just want to be gone. (*G1P19)

The comment above might indicate that the participant needs intervention to prevent further disengagement from the world and social work intervention can be used to assist such a person in a positive manner. Most social workers indicated that loneliness is a problem among older persons in residential facilities.

> *Yes, we have a lot of lonely people. There are a few who are just dropped here, and their children never came again. So, there is a very huge need to talk and they are always glad when I come. And the children overseas are a big problem.* (G2P2)

> *I think the minute your mobility decreases, then you become lonelier. The less mobile you are, the less chances you have.* (G2P4)

> *Loneliness also comes from rejection. They experience rejection when they are used to it that you come once a week. Now you relocate and only come once a term. They live for that day. It makes them lonely.* (G2P10)

From these narratives it can be concluded that several factors can give rise to loneliness, including a decline in mobility, poor social support systems and children relocating or emigrating, correlating with the views of Gentry and Palmer (2021), who indicated that ageing may also bring other challenges, exacerbating a solitary life and emotional poverty.

Theme 2 - Feelings of depression and how they manifest

As already indicated, depression can be an indicator of emotional poverty in older persons. This theme was divided into two sub-themes, as indicated below.

Sub-theme 2.1 Views on what depression is

As noted earlier, depression can be an indicator of emotional poverty in older persons. Older persons in residential facilities may have experienced several losses that could contribute to feelings of depression. Losses could include the death of a spouse, less freedom, limited mobility and little independence (McHugh et al., 2020; Queirós et al., 2021). Two participants in group 1 noted the following about depression:

> *I always had been comfortable with myself. You see, my mother died when I was young. She was actually bipolar. They called it in those days' manic depression but later on I realised she was bipolar. She used to be the life and soul of a party and suddenly she was gone. She was depressed. And how she died … there must have been an overdose, but I don't know what happened. In those days they didn't talk about it. I did not see a psychologist. Not in those days. Now they are much more open about it … Must have been in the family because then …* [her son] *went into a depression and started drinking. He went to a psychiatric hospital for six weeks and received wonderful treatment.* (G1P6)

> *Man, I was … something happened a few years ago and then I got depressed. They took me to the doctor and wanted to send me away because I was just sitting and staring and didn't do anything. I also didn't look after myself. And then they took me to somebody, and they helped me … talking sessions with someone to bring me out of the dark hole. A psychologist. I went there to go and talk every day, and it helped. They wanted to admit me, but they didn't.* (G1P11)

These comments or perceptions regarding depression are very insightful. G1P6 is a 96-year-old and treatments by a psychologist or therapist were unfamiliar to her. G1P11 received professional treatment and the outcome was positive. It can also be argued that G1P11 had better access to therapy services and its benefits compared to G1P6. This is important as, according to Luanaigh and Lawlor (2008), providing psychological services to older persons is vital. Another participant in group 1 summed up her life as follows:

> *So yes, I suffer from depression today. I have been put on anti-depressants, and I saw a psychologist … let me tell you. My life is a complete, complete, complete rubbish of a rubbish and I suffer from the violation of it. The divorce, I had a stroke, I had cancer … but the thing is this. There is never acknowledgement given to me.* (G1P20)

It is evident that G1P20's depression stems from several crises that occurred in her life. Service providers need to realise the need for mental health services for older persons. The comments above indicate some kind of understanding and comprehension of depression as an illness and

something real, but some participants did not have any insight into the nature of depression, as shown in the narratives below.

> *I actually do not believe in depression. I always think that because it has been overdone in such a big way in every country, people often use it to get out of situations. I don't want to be out of here because there are still my children and friends. When I am down, I go for a coffee.* (G1P7)

> *Depression? No, I don't know it.* (G1P10)

> *A person can probably get depression, but I believe in God, and I don't bother with things that aren't right*. (G1P15)

The comments above indicate that a number of participants were not convinced that depression is real and needs to be addressed accordingly. Luanaigh and Lawlor (2008) suggest there is a proclivity among older persons to "explain away" depression as a normal part of ageing and not an important condition for which help is needed. Because depression is such an important predictor for emotional poverty, it would assist the social work intervention process if older persons were made aware of depression and what it is, and intervention then might be more successful.

Some participants in group 1 had some insights into depression, as recorded below:

> *Depression, as I found out, feels like you are in a dark hole, and you don't see the light.* (G1P9)

> *Depression is when you don't have any interest in anything around you and you want to take your own life.* (G1P12)

> *You feel unhappy because everyone is looking at you* [stoma bag] *... that is when I actually don't want to be around people. The sister asked me yesterday why I am sitting in the room. I told her ... Sister, I don't want to be inside and sitting there between all the residents.* (G1P17)

These comments suggest that the residents can understand depression in terms of its emotional impact and how it makes them feel, showing a capacity and willingness to enter a psychological discussion/intervention. There is something encouraging in the comments, in that some older persons would most likely respond well to discussions with a health and social care professional about their feelings and mood. The comments from the social workers in group 2 on depression include the following:

> *I can't remember if I have ever dealt with suicide. Ideations yes. Especially where children prevent contact. Then older persons can get very depressed and then commit suicide.* (G2P3)

> *I think if you are older, you are at a vulnerable stage with all these life changes like retirement, loss of a spouse, loss of children and then there is a risk for these longstanding conditions to reach a very critical period.* (G2P6)

According to Earl and Marais (2023), there is limited research assessing the prevalence of depression and anxiety among older persons in South Africa. These authors explained that risk

factors include chronic health conditions, reduced family connections and also emphasised that residential living itself may be an independent risk factor. This leads to a loss of a societal role, autonomy and independence. These risk factors correlate well with the comments by G2P6. This sub-theme is important, confirming that there is still work to be done to classify depression as an illness and not a weakness.

Sub-theme 2.2 Different ways of dealing with depression

Participants in group 2 related how they assist older persons who are depressed, as indicated in the two narratives below.

> *That is why a lot of attention is being placed on mental health. It also depends on the support you have. But depression is on the rise. I am not quite a believer of over-medicating someone. When someone is diagnosed with depression, rather let us see what the root cause is and work from that source in order to help the resident deal with the disease … so if the medical report states that the patient is being treated for depression and anxiety, we will send the patient back for a psychiatric report as well.* (G2P9)

> *If a resident is really depressed, we will first look at biological causes. We first eliminate all the physical stuff and then there is a 40 to 50% chance that things are a bit better. We will pay special attention. And the solution for emotional poverty is to let someone feel wanted.* (G2P10)

Both participants thought it important to first look at the immediate trigger for the depression and then at the "root cause" of the current mood of the older persons, taking into consideration the biological/medical sphere, the psychological sphere and the social sphere (Nwakasi et al., 2021). There might be a decline in mobility and social contact. The following narratives illustrate what kind of help can be used against depression:

> *The reason why my depression is better is because I keep myself busy. Here is a workroom and I do the zips for the residents and if they want to make a dress smaller or bigger. And the shop around the corner, I go and buy the residents' stuff because a lot can't do it themselves.* (G1P14)

> *I think we try very hard to fight loneliness. I will literally sometimes go upstairs and request them to come down and mingle with the rest. I try very hard and will literally fetch them from their rooms. Our last guest speaker spoke about depression. Mmmm … yes, we try very hard. If you motivate them personally, they are more inclined to come*. (G2P4)

The narratives above show that these participants try to do specific things to keep them busy, as this would draw their attention away from how they are feeling. This connects very well with the research by Green (2017), finding that behavioural activation can work equally as well as cognitive behavioural therapy. It is a less complex approach and might be more suitable for older persons or cognitively impaired persons. So, the undertaking pleasant activities might help reduce depressive symptoms. Later-life depression is one of the main risk factors of subsequent dementia, while 12

to 15% of those with mild cognitive impairment succumb to dementia every year (Earl & Marais, 2023).

Theme 3 - Social isolation

Most of the participants in this study experienced isolation, especially during the Covid-19 lockdown. Sub-theme 3.1 captures some of the comments from the older persons. In sub-theme 3.2 the focus will be on possible general solutions to isolation.

Theme 3.1 Covid-19-related social isolation and its psychosocial effects

Older persons in residential facilities were especially affected by loneliness and isolation during the Covid-19 lockdown periods. Because of their vulnerability to infection, outside contact was limited or prohibited at these facilities. Simard and Volicer (2020) explained that this was the main reason that residents were cut off from contact with the outside world, unfortunately especially from their friends and family. As a result, a significant number of older persons in residential facilities experienced emotional poverty during Covid-19. Two participants in group 1 noted the following regarding their experiences during Covid-19:

> *Then I got Covid, and I was lying in the room for a very long time. I lay here for almost two weeks, very lonely and isolated. Yes, it was boring, and you think of a lot of things. You think a lot. Longing. You were not allowed to have visitors. They had to wear masks. But ok, everything is all right again now.* (G1P10)

> *I then got Covid-19 from a lady I had to cheer up … I just slept and was weak and slept the whole day and I was in isolation when the sister stormed in one morning and said, covid, covid, covid, you must go to the hospital. I answered and said that I am not going to the hospital. She then said I must, but I said that* [name] *went to hospital and she died the following evening. I then said I am just going to stay here. I am not putting my feet out that door. It was a very difficult time*. (G1P14)

> *I could not see my children at all. I couldn't go out. It was very bad for me because I am used to going out. You just had to sit here. It is a bit sad but what can you do. You just have to sit.* (G1P16)

It is evident from the comments above that it was extremely difficult for older persons in residential facilities not to have any contact with the outside world during Covid-19. These extended periods of confinement can be associated with psychological symptoms such as depression, anxiety and post-traumatic stress disorders, all related to emotional poverty (Jurblum et al., 2020). On the one hand, it was easy to understand why the isolation of older persons was necessary and that the safety precautions needed to be in place, but it was also obvious that these altered and truncated interactions greatly diminished social connectedness and increased their risk for social isolation, loneliness and depression, which most probably led to emotional poverty (Smith et al., 2020). Accordingly, Santini et al. (2020) conclude that the social isolation of older persons is a serious

mental health concern, as was also indicated by the social workers in group 2, in the comments below.

> *I think it was a really difficult time and yes there was the loneliness because people were often in their own room or people were not socialising like they were … what I saw much more is how vulnerable and fearful older persons were … they were now exposed to people in personal protective equipment and visors and masks and I think it is scary for anyone to be confronted with that all the time, especially older persons who have dementia or Alzheimer's disease and who aren't able to make sense of what is happening. So, it was awful and hard on a number of levels. Not just the isolation and loneliness but also the fear. Things changed all the time in residential facilities.* (G2P6)

> *Yes, as I said, they got very lonely and isolated during Covid. Very, very lonely. I stayed here for almost four months. The older persons can't understand. They ask … where are my children? Did the children forget about me? Every week or two we had to adjust the rules. Then the families could come to the fence and the carers had to take the residents to the gate and then they had to yell at each other. It didn't work because it was cold, and the residents couldn't hear … Yes, they really were very isolated. We were lucky with relatively few cases of death. But some passed away, not from Covid-19 but from isolation and loneliness. …And those that were dying, had to die alone, and couldn't see their children.* (G2P2)

It is clear from these narratives that Covid-19 had a negative impact on the lives of older persons in residential facilities. It is evident that they did not only experience emotional poverty during this time, but also the fear and anxiety of contracting Covid-19, as G2P2 mentioned that older persons passed away from isolation and loneliness and not only from Covid-19. It is thus clear that Covid-19 negatively affected older persons' wellbeing (Santini et al., 2020).

Theme 3.2 Different ways to reduce social isolation

Older persons were socially isolated not only during Covid-19. A considerable number of them in residential facilities still experienced isolation. Participants in group 2 offered the following suggestions to reduce isolation:

> *There are residents who still function well. I helped them to form a group who render services at the frail-care unit. They plan their activities, and we only give the equipment. They reach out to residents who feel isolated and cannot go out.* (G2P5)

> *In other words, if there is a resident we are concerned about, and notice that he/she is a bit isolated and not in the position to reach out, then we are always concerned about her safety. So, we will always arrange that the nursing staff make three or four contacts a day including a night visit.* (G2P7)

> *We motivate them to come for the exercises and for the concerts. We encourage independence. I often drink tea with them and involve them in this manner*. (G2P9)

Gerontological social work should always focus on ways to reduce the isolation of older persons. Both G2P5 and G2P7 suggested creative ways to reduce isolation in the residential facilities. Barken and Lowndes (2018) recommend that social workers who do gerontological social work should focus on a relation-centred or family-centred approach. Some other participants in group 2 also pointed to the importance of family and friends:

> *We don't restrict the families. There was a visiting hours-sign when I started here. It was the first thing I took off. Families are welcome from about 09:30 when everybody is ready for the day. We encourage it. Anytime. You can come and visit tonight as well. The resident with more contacts functions better.* (G2P2)

> *I am very involved with my residents. The sister comes and tells me who is struggling and then I talk to them and the families, especially nearer to the end of life.* (G2P8)

> *We have braai facilities, so if it is family or friends of a dementia resident, they can come and visit here and take the resident outside. It becomes a communal visiting place. Often all the children and friends come from several directions and visit together.* (G2P10)

These comments correlate with the view of Davison et al. (2019) that family members and close friends can be regarded as specialists on the residents with valuable knowledge about them and providing a sense of continuation between the life they had before moving to the residential facility and the present. Social workers who do gerontological social work can thus effectively involve family and friends of older persons to let them still feel connected to and part of the outside world.

DISCUSSION

In this study three themes were identified on the basis of the indicators of emotional poverty. From **theme 1, loneliness,** it is apparent that older persons sometimes deny the fact that they feel lonely and this affects their functioning and emotional wellbeing. It was also found that stigma still plays a significant role and that several older persons therefore do not acknowledge that they are lonely. Burgener et al. (2015) emphasise that older persons will often feel stigmatised if they admit they are lonely and experience feelings of social rejection. The role of spirituality was also indicated by participants of group 1. Parada (2022) observes that the role of spirituality in older persons' lives should not be overlooked by social workers who do gerontological social work. Loneliness felt by older persons could be attributed to several reasons such as loss of mobility and lack of social support; authors such as Atkins et al. (2013) and Gentry and Palmer (2021) accordingly reason that service providers, including social workers who do gerontological social work, could play a significant role in addressing loneliness of older persons.

In **theme 2, feelings of depression,** participants shared a range of views on the meaning of depression. It is significant that several participants in group 1 did not view depression as a reality. This could be ascribed to a lack of knowledge about depression, as well as a lack of access to psychological services. Earl and Marais (2023) found that there are insufficient resources for older persons who suffer from depression and anxiety. Some participants in group 1 acknowledged that

they experienced feelings of depression and had received professional help for their depression. Jafree et al. (2021) propose that all older persons in residential facilities should have access to counselling and mental health services. Social work participants also stressed the importance of such services. It was also confirmed that involvement in activities could reduce loneliness and feelings of depression.

Theme 3, social isolation, dealt with the emotional effects of Covid-19 and lockdown as well as ways to reduce social isolation. The devasting effect of the long periods of isolation was evident and most participants shared what a difficult time this was for them. Santini et al. (2020) conclude that the mental damage inflicted by social isolation on a vulnerable group such as older persons in residential facilities should not be underestimated. This was also indicated by several participants in this study. It is significant that one participant in group 2 believed older persons died not necessarily from Covid-19, but from isolation and loneliness. Landman and Rohman (2022) stated that social isolation also occurs in residential facilities, even though there are several residents. Participants in group 2 provided some possible solutions to combat such social isolation, including special activities for residents as well involving family and friends. Social workers who do gerontological work have an important role in preventing the social isolation of older persons in residential facilities (Genece, 2021).

CONCLUSIONS AND RECOMMENDATIONS

It can be concluded that the incidence of emotional poverty could be addressed successfully in rendering services to older persons to determine their overall wellbeing. From the narratives received from both groups, a conclusion that can be drawn is that loneliness, feelings of depression and isolation are useful predictors of emotional poverty. Emotional poverty is a phenomenon experienced by a considerable number of older persons, especially in residential facilities where they may experience feelings of loneliness, depression and social isolation. It can be confirmed that there are many misconceptions around loneliness and depression, making it difficult for older persons affected by this to reach out for help and support. It can also be concluded that social isolation often occurs in residential facilities and hence social workers who do gerontological social work should find ways to alleviate this.

Some recommendations are that social workers who do gerontological social work must familiarise themselves with the concept of emotional poverty and develop intervention plans to reduce it. Furthermore, social workers who do gerontological social work should continue to encourage interaction between older persons in residential facilities as this can alleviate emotional poverty. They could also utilise case work, group work and community work as a planned initiative to address loneliness, feelings of depression and social isolation of older persons. The term “emotional poverty” should be regarded as the umbrella term and the three indicators of loneliness, feelings of depression and social isolation be recognised as risk factors for emotional poverty. Recommendations for older persons regarding emotional poverty is that they should seek help when they feel lonely, depressed or isolated. Emotional poverty should be seen as a specific form

of poverty and be addressed as such by social workers who do gerontological social work as well as the rest of the multidisciplinary team.

It is also recommended that risk factors for loneliness should be addressed by ensuring sufficient interaction with the outside world. Mental health and specifically feelings of depression of older persons should be recognised and a conscious effort should be made to provide the necessary support and services to them. Further recommendations include that social workers should educate older persons about depression and psychological health and should refer possible mental health issues to other members of the multidisciplinary team, such as psychologists. Lastly, social workers need to create awareness amongst older persons about what depression is, emphasising that it is classified as an illness and not a weakness, and that it is socially acceptable to admit to experiencing depression and to be treated for it. Creative ways to combat social isolation should also be prioritised, including forming social networks from older people. It is also recommended that to fully comprehend how older persons experience emotional poverty as they grow older, a longitudinal study could be implemented to record how the residents adjust to transitions.

No study is without its limitations and acknowledging these is part of the research process. The following limitations of this study were identified:

• Some of the literature used in this study is dated. Recent literature was used as far as possible.

• This study focused only on older persons in residential facilities; older persons who are staying with their children or on their own were not included.

Despite these limitations, the concept of emotional poverty raises awareness of opportunities or considerations for studies of similar circumstances that may occur in future. This will help to ensure that older persons in residential facilities are regarded as a group that needs vital social work intervention to address emotional poverty.

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