Are Older People Living Alone Socially Isolated?

A Qualitative Study of Their Experiences

Maryse Soulières, Ph.D., SW

School of Social Work, University of Montreal, Montreal, Canada
Pavillon Lionel-Groulx, bureau C-7096
3150, rue Jean-Brillant, Montréal, Qc, H1T 1N8
514-343-6601
maryse.soulieres@umontreal.ca

Michèle Charpentier, Ph.D.

School of Social Work, Univeristé du Québec à Montréal, Montreal, Canada
charpentier.michele@uqam.ca

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This article discusses the experiences of social isolation among older people living alone. The current state of knowledge suggests that they are at a higher risk of social isolation which, in turn, can compromise their health and well-being to varying degrees. Yet, few qualitative studies have tried to understand the subjective experience of living alone and the ways it can impact older people's relationships. The data presented here are based on 43 individual interviews with men and women aged 65 to 93 living alone in the Montreal area (Canada), and group discussions with 120 actors involved in intervention. The results showed that the majority of the participating older people did not see living alone as a problem. Their stories revealed the extent of their resilience and their ability to maintain satisfactory social relations with family and peers. However, for a minority, mostly men over 80 years old, solo living translated into being alone and could become problematic. The article presents reflections for social work intervention, inviting practitioners to consider different vulnerabilities affecting the capacity of older people living alone to maintain their social networks and highlighting the importance of fostering reciprocity in their relationships.

Keywords: living alone; social isolation; qualitative study

Introduction

Far from a marginal reality, living alone is a lifestyle that is on the rise in Western countries. Based on observations of the different population strata, more and more older people are living alone. The 2016 census showed that in Quebec (Canada), where this study was conducted, one-third of older people (38% of women and 21% of men aged 65 years and over) lived alone in private households[1]. In those aged 85 and over, these figures rose to 56% of women and 29% of men (Rose, 2019). The day-to-day life of older people living alone, whether it be the result of a personal choice or of imposed life circumstances (widowhood, for example), raises concerns about their quality of life and well-being. Many studies have identified the complex, often-ambiguous relationships

[1] These statistics do not therefore include all older people living alone in collective settings, such as residences for seniors.

between solo living and poverty, mental health problems, and the risks of hospitalization and institutionalization (de Jong Gierveld, Keating & Fast, 2015; Pate, 2014; Friends of the Elderly, 2014). The fact of living alone also appears to increase the risks of mistreatment and of experiencing cognitive losses, depressive symptoms and suicidal ideation, and is very often associated with the social isolation of older people (National Seniors Council, 2014).

The concept of social isolation generally refers to an objective and a "measurable" situation that is characterized by a limited number – if not the absence – of interpersonal relationships, social roles and participation in the community (Nicholson, 2009; Keefe et al., 2006 ; Wenger et al., 1996; de Jong Gierveld and Kamphuls, 1985). Different Canadian surveys have estimated the prevalence of this phenomenon: over 30% of older adults appear to be at risk of experiencing social isolation (Keefe et al., 2006); one in four (24%) would like to participate in more social activities (Gilmour, 2012); and one in five (19%) would like to have more interpersonal relationships, a percentage that climbs to 50% in people aged 80 and over (Statistics Canada, 2012). A recent literature review (Kirouac and Charpentier, 2017) revealed the complex interaction among the "risk factors" for social isolation among older people; the fact of living alone is preponderant among them. Other factors include being older, being a woman[2], not having a spouse, living in a socio-economically precarious situation, and having physical and/or mental health problems (Valtorta, 2016; Pate 2014; Penning et al., 2014; Beaumont, 2013; Aartsen and Jylhä, 2011; de Jong Gierveld, Fokkema and van Tilburg, 2011; Wenger and Burholt, 2004; Havens et al., 2004).

At the same time, a few qualitative studies have provided important nuances regarding the dynamics at play, bringing into question the purely "objective" nature of the concept of social isolation. In particular, these studies indicate that for older people, the "perceived quality" of social relations is as important – if not more important – than the "quantity" or "frequency" of the contacts (de Jong Gierveld, Keating & Fast, 2015; Victor et al., 2000). Other studies show that the types of relationships maintained (family ties, friendships, love relationships, etc.) also play a role in the feeling of isolation and loneliness experienced by older people (de Jong Gierveld, Keating & Fast, 2015).

This article presents the results of an action research study[3] exploring how older people living alone perceive their day-to-day lives. More specifically, it analyzes the issue of the social relationships developed by these older people, with their diverse life trajectories: Do they consider themselves isolated? What strategies do they use to cope

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[2] Gender has been a controversial issue in the past few years. Contrary to the widely held belief that the experience of aging is more problematic for women (Charpentier et al., 2014; Krekula, 2007), recent studies have concluded that being a man, in Canada, is associated more significantly with loneliness than being a woman (de Jong Gierveld, Keating & Fast, 2015).

[3] "Vieillir et vivre seul.e" (Charpentier et al., 2019), funded by the Québec Ami des Aînés program of the Secrétariat aux Aînés (Government of Quebec).

with solo living and enjoy a satisfying social network? And when they do not succeed in doing so, what thoughts do they express that could shed light on possible intervention strategies? Based on the "sociology of experience" theory (Dubet, 1994)[4], which refers to the way in which individuals understand, make sense of and adapt to their reality, this study takes into account not only the objective living conditions of individuals – in this case, older people living alone – but also what they experience and their degree of autonomy. Following this introduction to the issues of living alone and the concept of social isolation, the next section describes the research methodology used. The main results are then presented, highlighting both the diversity of the social relationships developed by the majority of the older people interviewed and the strategies they use to maintain a satisfying day-to-day social life. We then look at the "solitary", those who are extremely isolated, and their particular social characteristics. The discussion section offers some reflections on social interventions aimed at older people living alone.

Methods

This study was conducted in the Greater Montreal area from 2016 to 2019[5] in partnership with Les Petits Frères, a community organization working with very old adults who are socially isolated[6]. This field partner's collaboration during all phases of the study grounded the process as closely as possible in the realities and concerns of practitioners, and facilitated the recruitment of isolated older adults who would otherwise have been hard to reach. The recruitment of participants also relied on in-person presentation of the project in different community centers for older people and word-of-mouth. The aims of the study were twofold: (1) first, to hear directly from older adults living alone in order to gain insight into their experiences and the strategies they use to meet their needs, and (2) second, on the clinical level, to generate reflection on the adequacy of current services in light of the experiences of the participating older people.

Adopting a comprehensive approach, data were collected from semi-structured individual interviews with 43 older people aged 65 to 93. Each interview lasted an average of 60 minutes and was usually conducted in the person's home (two participants asked for the interview to be held at the university). The participants lived

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[4] For Dubet (1994), "experience" refers to the way in which individuals apprehend their reality, reflect on it and react to it through different individual and collective practices or conduct. It reflects the relationship between objective living conditions and the autonomy margin of individuals - here elderly people living alone -, while taking into account their subjectivity and their feelings. This theory enabled our analyses to take into account the fact that experience varies from one individual to another depending on their social and personal history, their particular situation, their social environment and the constraints they encounter.

[5] Data collection took place prior to the COVID-19 pandemic, whose impacts on the social life of older people are therefore not reflected in these results.

[6] Les Petits Frères organization has over 2,000 volunteers throughout Quebec who assist isolated older people, whom they call their "*Vieux Amis* " (elder friends). www.lespetitsfreres.ca

alone in urban areas and in different types of dwellings: single-family homes or multiplex buildings, rental apartments, low-cost housing and housing cooperatives, and residences for seniors with or without services[7] Taking into account the previously identified risk factors for social isolation, the study sample was diversified in terms of gender, age, marital status, socio-economic conditions, ethnocultural background and health status (physical and mental). These efforts produced a diversified sample of Quebec older people living alone (n=43), based on the following characteristics:

- Gender: female (32); male (11)
- Age group: 65 to 79 years old (25); 80 years old and over (18)
- Marital status: single (17); widowed (14); separated/divorced (12)
- Length of time living alone: under 10 years (9); 10 to 25 years (11); over 25 years (23)
- Income level[8]: modest (30); average (10); high (3)
- Health status: self-reported physical health problems (27); self-reported mental health problems (8) [9]
- Immigration (10)

Composed of open-ended questions, the interview guide focussed on three main themes: (1) the participants' residential journey, with a particular look at their circumstances and perceptions of solo living; (2) their day-to-day lives in terms of their living environment (housekeeping, meals, etc.) and their social relationships; and (3) their strategies and resources for coping with solo living. With the participants' consent, all the interviews were audiotaped and transcribed verbatim. The qualitative analyses, drawing on the writings of Paillé and Mucchielli (2003) and Paillé (1994), were carried out in three steps: a first thematic analysis identified the primary and secondary themes in each interview; these thematic data were then grouped by conceptual category; lastly, a global analysis cross-referenced different analysis streams (gender, age, socio-economic conditions, etc.). A handful of in-depth intra-case analyses were also carried out, producing experiential portraits, particularly for the respondents living in "extremely isolated" situations (whom we described as "solitary").

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[7] Excluded from the study were older people living in housing settings administered by the public health and social services network, such as long-term care centres or nursing homes (known as *centres d'hébergement et de soins de longue durée*, or CHSLD, in Quebec).

[8] In this study, an annual income of CAN$50,000 was considered high, while modest incomes were considered to be CAN$25,000 or less per year. The low-income cut-off for a person living alone in an urban area is set at roughly CAN$22,000 (Statistics Canada, Table 11-10-0241-01 – Low income cut-offs (LICOs) before and after tax by community size and family size, in current dollars).

[9] These figures are based on the participants' self-reported health status. The main physical health problems reported were arthritis/osteoarthritis, diabetes, cancer, hemiplegia (stroke) and mobility issues. The mental health problems reported involved anxiety or depressive disorders. These health problems were related to losses of functional autonomy ranging from minor to major.

These analyses were enriched by a second metholodogical phase in which the preliminary results were presented to over 120 actors (6 groups[10]) concerned with solo living among older people: psychosocial practitioners, volunteers, heads of support services and organizations, and decision makers. Drawing on communities of practice and expert consensus (Lecomte, 2003), this second phase served to validate, nuance and enhance the analysis, in addition to producing recommendations grounded in clinical practice realities. These recommendations are discussed in the conclusion of this article.

Results

Generally speaking, the results of the study provide a portrait that diverges from the stereotypes. Even though the majority of the participating older people faced difficulties that could limit their ability to maintain satisfying social relations (significant losses of functional autonomy, precarious and restrictive socio-economic conditions, etc.), according to most of those interviewed, the fact of living alone did not mean social isolation. The study highlights the "full" social lives and wide range of strategies they used to maintain and develop their social relations. It also provides a better understanding of the experience and needs of a minority of the respondents who were extremely socially isolated ("solitary") and for whom specific interventions should be envisaged.

Diverse social relationships

As was expected, more often than not, the participating older people's children occupied a special place in their social relations. The majority of the study participants (29 out of 43) had children, and most spoke about having very close relationships with them. These relationships often resulted in one or another form of support, depending on the participants' needs: domestic tasks, shopping, accompanying them to medical appointments, etc. Yet even more noteworthy, analyses showed how these relationships provided the participants with a "network of belonging" and gave them a sense that "they mattered to someone." For Pauline (aged 85), for example, the importance of her special relationship with her son was clear: "I have a son who's a gem! I tell you, he keeps me alive! I don't mean in terms of money, but he calls me every night!" We noted that some participants who either had no children, or who – for one reason or another – no longer had relationships with their children, had developed special connections with "young people" close to them (grandchildren, nieces, the children of good friends). In these cases, the participants spoke of these young people with the same pride as those who spoke to us about their children.

Our data also shed interesting light on the important role of intragenerational ties with siblings, friends and neighbours in everyday life. The participants spoke first of

[10] Facilitated by the lead investigator (Charpentier) and the study coordinator (Soulieres), the meetings were held in different settings: community groups, establishments in the public health and social services network, seniors' associations, etc.

relationships of trust and caring that spanned several decades. These relationship sgave them a feeling a continuity and stability, at a time when several facets of their life could be radically disrupted by the various changes that come with aging (loss of autonomy, widowhood, moving into a residence, etc.). Odette (aged 79), for example, stressed her close relationship with her brother: "We're like Siamese twins; we call each other every day!" Similarly, "good friends" – often few in number and presented as a "chosen family" – can provide invaluable moral support when faced with life's hardships:

> I have good friends. (…) I have one who's been like a brother to me, for 30 years (…) [He] helped me a lot when my wife died. (…) I've got [another friend], a bit younger; sometimes we go out to meet women, things like that. (Daniel, aged 71)

Moreover, the interviews revealed the place occupied by more recent friendships in the social life of older people living alone. Whether new neighbours in their new accommodations, or people met in various activities or places where they spent time, these connections were formed around common interests, out of a desire to socialize, or again, around casual solidarities. For Yvonne (aged 73), who had had a difficult life's journey (lost contact with her children, whom she gave up for adoption at a young age; separation from an alcoholic husband; cancer that left her with serious physical sequelae), the connections made with the residents in her building were invaluable: *« "Meals, little games, concerts. (…) We're a closer group. (…) We occupy two tables in the cafeteria. (…) I feel less alone."*

Lastly, nearly all the participants talked about romance, whether it be actual or hoped for relationships. The respondents who were not in couples (the vast majority) displayed ambivalence. On the one hand, several expressed, more or less directly, a crucial need for intimacy and a sexual life, thus refuting the persistent biases about older adults' sexuality. For example, Léa (aged 70) said that she "fantasized a lot" and that she missed having a man in her life – particularly at night – to "go to bed with." On the other hand, the results revealed different types of reticence related notably to painful memories (break-ups or grieving processes, history of conjugal violence, etc.). For some, mostly women, their ambivalence about love resulted more from a fear of losing the advantages associated with their current solo lifestyle and of endangering their independence and freedom. The few participants (three women and one man) who were in couples at the time of the interview, but who were still living alone, described having a relationship characterized by tenderness and intimacy and that provided them with shared activities and some sense of security. These four participants saw the fact of not cohabiting with their partner as the result of a conscious and deliberate choice grounded in the desire to preserve their independence and freedom.

> Personally, after my divorce, which was pretty difficult, I wouldn't start again. (…) We go out a lot. But living together? No. For me, that's my choice (Édith, aged 70)

> When I started going out with my boyfriend, I said to myself, "No, I won't let him into the house." Because I want the children to come back, to feel they were still home. (Viviane, aged 87)

Adjusted strategies to prevent social isolation

While our study highlighted the diversity of social relationships in the aging experience of individuals living alone, it also revealed the scope of the strategies used by older people to preserve, and if needed, to develop, meaningful connections and maintain a place in the social sphere. In this respect, it refutes the victimizing images of passive older people suffering from the repercussions of social isolation, inviting practitioners to focus on special strategies in their support interventions. A number of respondents reported grabbing every opportunity that arose to maintain thecrelationsips they had left, in any way whatsoever. Their stories underscore the strategies used to compensate for the cumulative risk factors for social isolation, related primarily to advancing age and solo living: erosion of their social network (death or serious illness), moves, losses of mobility that curtail outings, etc. "We're all at approximately the same point in terms of our health, (…) so that outings with friends, well, they happen less frequently than before" (Pauline, aged 85).

Thus, when "in-person" contacts declined, some respondents reported replacing them by phone contacts. For others, notably the immigrant older people in our sample (10), learning how to use the Internet and the various social media enabled them to stay in touch with people who were far away. Their level of mastery of different computer technologies, often facilitated by the instruction and support provided by a family member or a friend, also debunked numerous stereotypes. Several of the respondents had learned, at a fairly advanced age, to send messages via email or Facebook or to hold video conversations (via Skype or other applications). At age 81, Claudette had even created a blog: "I'm in touch with lots of people. I can express myself on this blog. I can say things; and I get a lot out of it."

In addition, strategies that created opportunities to meet and stay active in social networks were revealed. For several respondents, participating in various leisure, sports or artistic activities, or in different services offered to people who are losing their autonomy (meals at the community hall, assistance with food shopping, etc.) did not relate solely to a desire for entertainment or an identified need (food, for example), but also – if not primarily – served a specifically "social" function. Vivianne (aged 87) explained this dual function when speaking about her weekly dance classes: "first, it's exercise; second, all my friends are there!" This reflection obliges us to broaden our understanding of, not only the activities, but also the various services and types of care offered to older people living alone. It shows how important it is to take into account, promote and foster their social potential when offering services to a person living alone.

While this ability to maintain and rekindle the social relationships we have identified can be related to individual personality traits (particularly sociability), it also appeared to be closely linked to factors that were external to the person. The various physical or functional limitations that had an uneven impact on the daily life of the individuals interviewed are one such example. Various social determinants, including the financial, cultural and social resources to which the participants may or may not have had access, is another example. It must be remembered that two-thirds of the participants had annual incomes of less than $25,000. Do these people really have the

financial means to register for activities, get around, or invite friends to a local restaurant?

Socially isolated older people

While the majority of the older people we interviewed had a satisfying social network (sometimes despite major obstacles in terms of physical or mental health or financial resources), the situation was precarious, if not worrisome, for a certain number of other participants. In our study, we interviewed nine respondents (20% of the sample) who could be regarded as extremely socially isolated[11]. Our identification of these participants as "solitary" resulted from the research team's analysis of their situation and does not necessarily reflect the subjective opinion expressed by the participants.

The interviews with these respondents revealed a solitary daily existence in which human contact was virtually absent, despite the presence of a few interpersonal relationships in their lives. The social isolation of this minority was extreme, and generated (in some more than others) a feeling of loneliness and disconnection from the world and society. It also translated into – and this constitutes a crucial concern in psychosocial intervention – a difficulty in obtaining various types of assistance or informal support. We observed these older people have difficulty, if not an inability, to identify someone in their inner circle who could come help them quickly if needed.[12]. With a view to informing clinical reflections, we propose a general portrait here, as well as two distinct profiles for these extremely socially isolated older people.

The majority of these nine extremely isolated respondents were men (6), aged 80 years or over (6), single (5) and had lived most of their lives alone (7 of them for over 30 years). They presented major vulnerability factors: they all had annual incomes of less than $25,000 and all reported having had physical and/or mental health problems. Their migration journey, by uprooting them from their social environment, seemed to have contributed to the social isolation of three of them.

Beyond these general characteristics, the qualitative analyses differentiated two distinct profiles of social isolation. The first profile consisted of participants whose current isolation resulted primarily from a series of transitions and/or losses that had eroded their social relations. A number of studies (such as that by Gravel, 2016) have already shown how aging can lead to such losses in terms of social network, particularly in old age: loss of autonomy that makes get-togethers more difficult, moves, or the serious illnesses and deaths of family members. The isolated older people' stories showed the degree to which these events could be experienced as true crisis moments having a major impact on their social lives. These hardships accumulate over the years.

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[11] Our recruitment methods, which targeted community organizations working with vulnerable older people, may have contributed to this profile in our sample.

[12] Part of the interview guide was devoted to scenarios (worrisome health problem experienced; lack of food; etc.) in which the respondents were asked to imagine oneself and to indicate, (1) if it concerned a situation that had already occurred or that could realistically happen to them, and (2) which strategies they could envisage to cope with this type of situation.

Such was the case for Micheline (aged 85), who, in the year prior to our interview, had lost her spouse, been obliged to move into a residence, and had lost contact with her children. Understandably she did not have the energy needed to adapt proactively to her new living environment. The same applied to Georgette (aged 87), who had lost numerous loved ones during the past 15 years (spouse, all her siblings, nephews and nieces, friends): "at my age, all my friends are dead." These multiple losses undermine and destabilize the person and sometimes result in extreme social isolation. The older people who fit this profile of isolation clearly needed support and assistance, yet the interviews revealed that either social and psychological services were not present or were inadequate to meet these needs.

The second profile consisted of older people who could be described as "solitary". In our study, four respondents fit this profile; all were men. The life's journey of these men had always been somewhat marginal. Single for the most part (one had been married prior to a separation), they had few connections with their family and few or no friends, if any. What they had in common was that they were fully absorbed in their hobbies, such as photography, reading, music or genealogy, which they carried out alone at home. All these older men also had the feeling that they had nothing in common with the people around them, whose conversations and occupations they often found meaningless, as illustrated in the comments made by Armand (aged 78) about the residents in his apartment building:

> They do activities downstairs. (…) But I just can't mix with them. I like to stay home. (…) I tried to eat with them a couple of times… But that's just impossible. Personally, the song 'Quand le soleil dit bonjour aux montagnes' is not my style. Nor is Bingo. (Armand, aged 78)

In summary, these men presented their social isolation as a more or less conscious choice that suited their solitary personality to withdraw from social relations that they found meaningless: "I prefer to be alone than to be with people who bore me. (…) I'm a solitary person." (Jules, aged 82). Their comments nuanced the importance placed on social relationships by the majority of the older people living alone whom we met; a small social network was not necessarily negative for everyone.

However, whether this social isolation was the result of a choice or not, questions remain. If these older people had a problem or a hardship in their lives, would they obtain the assistance and support needed? Gédéon (aged 88), for example, explained that his landlord might evict him from his lodging, and confided in us that he did not know how he could organize a move without some outside help. In terms of social intervention, this raises legitimate concerns that we will now discuss.

Discussion

The analyses conducted in this study point to some possible strategies for continuously improving psychosocial interventions with older people living alone. First, given the resilience of the people interviewed, the results presented could give the impression that

aging alone is a smooth process. Yet, the difficulties and social inequalities that came to light were very real. By diversifying our sample and paying specific attention to the respondents' gender, age, marital status, ethnocultural background, socio-economic conditions, and physical and mental health, we succeeded in taking into account and analyzing the risk factors for social isolation identified in the literature. Our exploration (Crenshaw, 1994; Poiret, 2005; Dorlin, 2008) of the experiences from an intersectional perspective highlighted how the interaction between various social disadvantage factors can have major impacts on people's living conditions and on the resources (personal, formal and informal) to which they may have access in order to adapt to the challenges of solo living (Callander et al., 2012). We were able, for example, to identify a number social disadvantage factors that characterized the extremely isolated older people in our sample: male, over 80, single, and financially precarious. More research would be needed in order to investigate other social factors that may influence social isolation in older people living alone. Our research is indeed limited by the fact that it did not include, for example, older people living alone in nursing homes or in rural and semi-rural areas, nor was it representative of the diversity of older people population (in terms of ethnicity, sexual orientation, etc.). Nonetheless, we believe our results support the idea that an intersectional perspective should inform interventions. This would allow both for a more effective targeting of older people living alone who are at risk of social isolation and for proposing interventions that take into account the resources these individuals actually have.

Our analysis of the interviews revealed another point which – central to the testimony of a majority of the respondents – should inform practices involving them. In their efforts to respond optimally to the needs of older people living alone, intervention practitioners may tend to regard their clients' family members mainly as potential caregivers. While revealing the respondents' gratitude to their caregivers, the collected stories also reflected their clear desire to focus on reciprocity and on their own, many contributions to the lives of others, their family, the community and society. Sometimes they saw this contribution as a question of giving their time, being a good listener or providing emotional support to who were going through difficult times or feeling lonely. For others, it meant offering different types of support. For example, Lyne (aged 65) mentioned her brother's limited cooking skills and that she invited him regularly to eat at her place and also gave him "bags of lunch." Armand (aged 78) spoke about exchanging resources with a good friend: "I can count on him and he can count on me. I'd do anything for him if he was in a tough spot. And the same goes for him. So we help each other out." Others babysat their grandchildren or filled a caregiver role themselves for someone in their inner circle.

Moreover, a recent Canadian study found that more respondents aged 75 and over defined themselves as caregivers (35%) than as beneficiaries of care from their family members (20%) (Sheets et al., 2018 : 92). For a few respondents, this took concrete monetary form in that they paid their children, neighbours or the concierge for the help they provided. Similarly, despite a very modest income, Thy (aged 88) felt it important to support his grandson in his studies: "Every month, I give him $200 to encourage him. (…) And then, he speaks Vietnamese with me. Whereas the others don't

know Vietnamese." Lastly, half of the participants (22 older people out of 43) were socially active, whether by sitting on various committees (residents' committees, boards of directors, political parties), or by volunteering with different neighbourhood organizations. Signifying a divergence from the comments that cite losses and dependence as the focal point of the older people' social relations, our analysis suggests the need to refocus interventions on the social – not strictly practical – nature of older people' interactions and to promote mechanisms that will allow for reciprocity in their relationships.

Conclusion

The results of this study point to a number of clinical recommendations pertaining to the social network of older adults who live alone. First, practitioners should broaden their usual understanding of the social network of these older people. Relinquishing a utilitarian view of social relationships aimed purely at meeting needs, interventions should promote social relationships that allow older adults living alone to feel as if they are part of and actively involved in social networks, the community and the society to which they contribute. Similarly, the results reveal the importance of recognizing the central role that – beyond children – peers can play in the social life of older people living alone, whether the peers are siblings, friends, or even lovers. Particularly when a loss of autonomy complicates "in-person" get-togethers, interventions should facilitate and support "remote" contacts, whether by phone or via other electronic technologies.

The results futher revealed that for the majority of the older people interviewed, solo living did not translate into a situation of social isolation, and in fact highlighted their great resilience in creating and maintaining satisfying social relationships. However, a minority of respondents confirmed the major repercussions that social isolation can have on older people living alone. While the expressed need for socializing varied among these isolated individuals – some suffered from loneliness while others said they appreciated it – their situations nonetheless raise concerns about their ability to obtain support in the potential crisis or transition situations that occur with advancing age, particularly among older people (e.g. deaths, moves, losses of physical and cognitive autonomy, etc.). All this calls for reflection on the ways in which social interventions can contribute to creating a safety net around these people, and thus, better meet their needs.

Lastly, the analyses conducted show the impact of social inequalities and the cumulative effects of several vulnerability factors (age, gender, income, migration journey, etc.) on individual resilience. Interventions should therefore incorporate an intersectional understanding that takes into consideration and limits, inasmuch as possible, the structural obstacles to socializations and social participation for older adults living alone.

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