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“It's the worst bloody feeling in the world”: Experiences of loneliness and social isolation among older people living in care homes



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ABSTRACT

Loneliness and social isolation in later life result in social exclusion, reduced well-being, and significant health problems. Yet, we have a limited understanding of the meanings that older people ascribe to loneliness and social isolation, and how they live through and cope with these issues. The scarce research on the topic largely reflects the experiences of older people living in the community. Less is known about the lived experiences of those in institutionalized settings, despite this group's vulnerability to loneliness and social isolation. To address this gap, we conducted a six-month multi-method qualitative study in two Australian care homes. The study included participant observation and interviews with twenty-two residents experiencing (or at risk) of loneliness and/or social isolation. Our findings show that participants understood loneliness and social isolation as relational and associated with aging (age-related contexts, norms, status), personal troubles, and sickness. They therefore situated loneliness and social isolation as multidimensional phenomena: related to both structural (e.g., aging) and agentic (e.g., personal choices) dimensions. Although participants acknowledged the structural aspects of loneliness and isolation, most felt it was their own responsibility to address it. They employed individual and social strategies to cope with and regulate disclosure of loneliness and isolation. Our study drew on interactionism and situationism (Erving Goffman) along with an emotion work approach (Arlie Hochschild) to provide a richer understanding of the lived experiences of loneliness and social isolation among frail older people living in care homes.

Introduction

In 2018, the British government appointed a minister for loneliness as evidence mounts that loneliness makes us sick (Prime Minister's Office, 2018). Globally, other ministers — including the Australian and Canadian Ministers for Seniors (Australian Government, 2018; Government of Canada, 2018) — are also concerned with the impact of loneliness and social isolation among older people (aged 65+). Whilst related and with similar negative effects, social isolation and loneliness are distinct concepts. Social isolation relates to low or non-existent levels of social participation and decreased social relationships and support (Cloutier-Fisher, Kobayashi, & Smith, 2011; Cornwell & Waite, 2009). Loneliness is a subjective experience, referring to a perceived difference between desired and actual levels of social relations and the consequent feeling of being alone or lacking companionship (Perلمان & Peplau, 1981; Smith, 2017).

Estimates of social isolation and loneliness among older people vary, depending on the country and measures applied. The literature indicates that between 5% and 17% are socially isolated (Shankar, Hamer, McMunn, & Steptoe, 2013), and between 12% and 30% experience loneliness (Ong et al., 2016; Tomstad, Dale, Sundsli, Søvareid, & Söderhamn, 2017). Prevalence is expected to increase as the aging population grows (Alpert, 2017), which is concerning due to the negative social and health effects of loneliness and social isolation in later life.

Lonely and socially isolated older people are more likely to experience depression (Gonyea, Curley, Meleki, Levine, & Lee, 2018), dementia (Holwerda et al., 2014), chronic pain (Jaremka et al., 2014; Smith, 2017), physical frailty (Gale, Westbury, & Cooper, 2017), and a range of terminal illnesses (Chan, Raman, Ma, & Malhotra, 2015; Tilvis et al., 2012). For many, this entails increased care needs, affecting their independence and social participation (Shankar, McMunn, Demakakos,

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Hamer, & Steptoe, 2017). Isolated or lonely older people often face social exclusion, low social and civic engagement, and a breakdown in family and community relationships (Weldrick & Grenier, 2018). Social isolation and loneliness are therefore social and public health concerns. Research on how older people experience and address loneliness and isolation is vital to improve care-practices and inform policy interventions that acknowledge diverse personal contexts and preferences (Cattan, White, Bond, & Learmouth, 2005; Neves, Franz, Judges, Beermann, & Baecker, 2019).

Qualitative research on older people's lived experience of loneliness and social isolation is scant (Cloutier-Fisher et al., 2011; Paque, Bastiaens, Van Bogaert, & Dilles, 2018; Sullivan, Victor, & Thomas, 2016). We still have an inadequate understanding of: 1) the meanings that older people ascribe to loneliness and isolation and 2) what they do to address these issues in everyday life. Existing research also largely reflects the experiences of older people living in the community, despite evidence that those in care homes are particularly vulnerable to social isolation and loneliness (Prieto-Flores, Forjaz, Fernandez-Mayoralas, Rojo-Perez, & Martinez-Martin, 2011; Victor, Scambler, & Bond, 2009).

To address these gaps, we conducted a six-month qualitative study in two care homes. Our aim was to better understand how frail older people experience social isolation and loneliness. To provide a comprehensive insight into personal experiences of the phenomena, we conducted interviews with frail residents and observed their immediate social and physical environments, namely living settings and related social norms and expectations. Frailty was defined as a combination of biomedical and psychosocial factors, including physical weakness, slow walking speed, low physical activity, self-reported exhaustion, and low psychosocial resilience (Lally & Crome, 2007).

This article explores lived experiences of loneliness and social isolation through a sociological lens – a comprehensive approach that brings together agentic (e.g., individual actions or personal choices) and structural (e.g., living arrangements) dimensions. In addition to studying how frail older adults living in care homes understand loneliness and social isolation, we considered the actions or strategies they employed to live through these experiences. We also contrasted their understandings and strategies with their contexts regarding options and constraints offered by the care homes. Embedded in this interplay of agency and structure we found self-presentation tensions (i.e., how older adults in our study saw themselves and how they wanted others to see them) (Goffman, 1959), 'oldering' norms and expectations (i.e., related to 'being old'), and diverse emotion work used to cope with loneliness and isolation in particular late-life settings (Hochschild, 1979).

Understanding loneliness and social isolation in later life

Lived experiences

Lived experiences of socially isolated and lonely older people remain largely absent from the literature (Sullivan et al., 2016). The scarce existing research has found that older people characterize loneliness and social isolation as defined by and dependent upon their relationships (McHugh, Hannigan, Carney, & Lawlor, 2017; Schoenmakers & Tindemans, 2017). Loneliness is also seen as corresponding to and a consequence of being alone (McHugh et al., 2017; Schoenmakers & Tindemans, 2017). Yet, loneliness is frequently identified as a feeling that can be present even when in the company of others; thus loneliness is both related to, and distinct from, social isolation (McHugh et al., 2017; Stanley et al., 2010).

Older people view loneliness and social isolation as private matters, "not only difficult to describe and put into words but also difficult to speak of and about" (Stanley et al., 2010, pp. 409–410), which emphasizes the need for more qualitative inquiry. Similarly, loneliness is framed as silent suffering – a vulnerability that older people often hide from fear of imposing on others or feeling socially alienated (McInnis &

White, 2001). The stigma attached to loneliness contributes to its positioning as a private matter (McInnis & White, 2001; Stanley et al., 2010).

But for some older people, experiences of isolation and loneliness are neither essentially negative nor outside of their control; they self-identify as 'loners' with a lifelong preference for their own company (Cloutier-Fisher et al., 2011). This led Cloutier-Fisher et al. (2011) to highlight that social isolation can be voluntary. Likewise, McHugh et al. (2017) found that some older people preferred to be alone, even characterizing their solitude as a protective factor against loneliness. Nonetheless, most research shows that an unfulfilled need for social relationships is a central factor contributing to loneliness and social isolation (Dickens, Richards, Greaves, & Campbell, 2011; Paque et al., 2018). In addition, engaging in social activities is older adults' preferred way to deal with loneliness in later life (Azaredo & Afonso, 2016) and social and group-based interventions have been successful in addressing both isolation and loneliness (Dickens et al., 2011; Winstead, Yost, Cotten, Berkowsky, & Anderson, 2014). This research emphasizes the importance of social and relational meanings and practices related to loneliness and isolation.

The studies discussed above, however, tend to focus on older people living in the community. Research on the lived experiences of older people living in care homes is noticeably limited. An exception is Paque and colleagues' study (2018) that explored loneliness among older people living in Belgian care homes. The authors concluded that loneliness was associated with lack of meaningful relationships and loss of autonomy and self-determination. To extend this important area of research and provide insights into both the experiences and practices of loneliness and social isolation in later life, we explored the meanings that frail older people in care homes attribute to these issues and the mechanisms they utilize to live/cope with them.

Theoretical approach

Loneliness and social isolation are typically understood through existential or psychological approaches. The first describes these experiences as natural aspects of the human condition (Yalom, 1980), and therefore focuses on how people handle them (Sundström, Rämgård, & Blomqvist, 2018). The second positions them as subjective and often associated with experiences of depression and anxiety (Taylor, Taylor, Nguyen, & Chatters, 2018). We draw on a sociological approach that instead situates loneliness and social isolation within the wider social milieu in which they are experienced (Franklin et al., 2018). This means bridging the individual and social by considering how individuals' isolation and loneliness shape and are shaped by social factors such as living arrangements, sociocultural norms, and socioeconomic status (McHugh et al., 2017; Schirmer & Michailakis, 2016).

Using this sociological lens, we explored structural (e.g., living settings, norms, etc.) and agentic (e.g., individual's actions, choices) dimensions to better understand loneliness and social isolation in later life. In particular, we employed Erving Goffman's (1967) symbolic interactionism to link agency and structure through social interaction. In a Goffmanian perspective, how we interact in social settings influences and is influenced by structures and contexts. Our analysis of loneliness and isolation is specifically informed by Goffman's work on stigma, identity, self-presentation, and institutionalization (Goffman, 1959, 1961, 1967, 1972). For Goffman (1963), stigma is a dynamic attribute or process that is built on social identities – identities that in turn rely on categories and attributes produced and reproduced in social interaction. If an individual is associated with a stigmatizing attribute (e.g., a character trait or physical element), they move from a social categorization of "normal" to a "discredited" or "discreditable" status (Goffman, 1959, 1963). Those stigmatizing attributes are based on a disconnect between one's "virtual social identity" (the attributes or character we ascribe to an individual) and their current or "actual social identity" (Goffman, 1963, p. 3). As noted above, loneliness is often seen

as carrying a social stigma, making it difficult for people to talk about because of its potential impact on a person's social identity (McInnis & White, 2001; Stanley et al., 2010). Consequently, those experiencing loneliness or social isolation may engage in efforts that Goffman (1959) termed 'self-presentation' and 'impression management'. Here, individuals attempt to control how others see them, through expressing the self and interacting in ways that create and perform a desired identity so as to reduce stigma (Goffman, 1959). Thus, self-presentation and impression management closely intertwine with stigma and identity. To understand how and why loneliness and social isolation are stigmatizing – and the ensuing internalization of this stigma that leads to older adults' 'silent suffering' (McInnis & White, 2001) – we need to understand not only individual meanings but also the localized social and cultural contexts within which they are situated (Kleinman & Hall-Clifford, 2009). Therefore, exploring both agentic and structural dimensions is critical to developing an understanding of loneliness and social isolation.

The main localized contexts of our participants were the care homes where they lived. Goffman conceptualized these types of environments as 'total institutions': "place[s] of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (1961, p. xiii). Total institutions are characterized by four totalistic features that shape social interaction and impact processes of identity and stigma creation:

First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity will be carried out in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole circle of activities being imposed from above through a system of explicit formal rulings and a body of officials. Finally, the contents of the various enforced activities are brought together as parts of a single overall rational plan purportedly designed to fulfil the official aims of the institution (Goffman, 1961, p. 6).

Defining characteristics of total institutions are social control based on 'house rules and privileges' and uniform circumstances that require both adaptation and withdrawal from a past self (Goffman, 1961). These characteristics can shape social interaction, thus affecting loneliness and social isolation. Goffman's perspective is still timely, as despite considerable changes in care services in the last decades, care homes remain total institutions because of the uniformization, standardization, and routinization of life for their residents and staff (Brossard, 2016).

While our study was primarily underpinned by a Goffmanian perspective, the data analysis led to the need to engage with additional perspectives on social interaction and emotions. Therefore, the concept of emotion work (or emotion management) – as developed by Arlie Hochschild (1979), expanding on Goffman's work – provided a further theoretical lens to our study, especially to highlight how people live through experiences of loneliness and social isolation. According to Hochschild, emotion work is "the act of trying to change in degree or quality of an emotion or feeling" (1979, p. 561). To "work on" an emotion or feeling is, for our purposes, the same as 'to manage' an emotion" (Hochschild, 1979, p. 561). But emotion work does not relate to suppression of emotion per se – rather it is a broad approach to shaping emotions that can include suppression. In addition, emotion work equals the act of trying or attempting to, not the outcome. Hochschild (1979) defined techniques of emotion work that, though different, can be adjunct to each other: cognitive, which encompasses efforts to modify ideas, thoughts or images in an attempt to change the feelings related to them; bodily, which refers to the effort to change physical outcomes of emotion, such as trying to breathe slower; and

expressive, which relates to the act of modifying gestures aiming to change inner feelings, such as trying to smile.

Intrinsically connected to emotion work is what Hochschild (1983) defines as "feeling rules". Within an interactionist perspective, these rules relate to social guidelines of feeling but also to norms about how to display that feeling – as identified by Hochschild, "we know feeling rules, too, from how others react to what they infer from our emotive display" (1979, p. 564). These social rules (duties and rights) frame the extent, direction, and duration of a feeling depending on its context, and provide insights into social convention and social control. Moreover, a distinction can be made between what we can expect to feel in a particular situation and how we think we should feel in that situation; we tend to idealize how we should feel in a given context and constantly compare our experience against idealized expectations. As such, "it is left for motivation ("what I want to feel") to mediate between feeling rule ("what I should feel") and emotion work ("what I try to feel")" (Hochschild, 1979, p. 565). These feeling rules are comparable to other rules of social interaction (Goffman, 1961), as perceptions and comportments are delineated within given values, circumstances, and social groups (Hochschild, 1979). Hochschild (1983) differentiates emotion work from emotional labor, as the former is situated within a private setting whereas the latter within a public and waged position. These concepts provided detailed tools to analyze the lived experiences of loneliness and social isolation among older people, particularly to make sense of how participants dealt, managed, or coped with them.

Methods

We explored how older people (aged 65+) living in care homes experience, articulate, and respond to social isolation and loneliness. The study was based on a multi-method qualitative approach that included participant observation and interviews. Following interactionism and situationism as theoretical approaches (Goffman, 1967), we offer an in-depth understanding of the social milieu surrounding and shaping participants' lives to situate the perceptions and experiences shared during interviews. Participant observation was critical to provide an understanding of the social and spatial context of participants and how that context shaped their experiences and articulations of loneliness and isolation. Additionally, the participant observation data informed the development of the interview guide and provided insights to further probe experiences of participants. As noted by Kleinman and Hall-Clifford (2009) in their studies on social interaction and stigma, researchers following a perspective focused on both sociocultural and individual dynamics should combine interviews with field observations. The project was approved by the human ethics committee of the University of Melbourne.

Design and data collection

We designed a multi-method qualitative study with two stages. In the first stage, the first two authors spent six months conducting 101 hours of participant observation in two residential care homes to observe broader spatial, social, and structural dynamics within the institutions. Observation occurred during meal times, in-house program activities, holiday celebrations, and while participants were engaged in informal activities such as frequenting communal areas. This facilitated a comprehensive grasp of daily routines, interpersonal relationships (between residents, staff, and visitors), living arrangements, and institutional norms and expectations. It also helped to explore and document agentic and structural dimensions within the institutional settings that informed and contextualized the interviews.

The first two authors then conducted hour-long semi-structured interviews with 22 residents experiencing or at risk of loneliness and social isolation. Participants at risk of loneliness and social isolation were identified by staff, and included residents vulnerable to these experiences due to prior feelings of loneliness, family loss, lack of social

support, or health decline. We developed the interview guide through a close reading of existing literature pertaining to aging, loneliness, and social isolation. This engagement with prior literature provided “theoretical sensitivity” (Corbin & Strauss, 1990, p. 41), allowing us to further develop, test, and contribute insights about concepts and models related to the phenomena being studied. The interview guide was also adjusted to our findings from the observation period. In the interview, we asked participants to share their understandings and experiences of social isolation and loneliness and reflect on how they lived through it.

Research sites

The research sites were two aged care homes in Melbourne, Australia. Both are privately-operated facilities situated in semi-industrial neighbourhoods with high levels of migrant settlement, cultural diversity, and socioeconomic disadvantage (Australian Bureau of Statistics, 2011). Both offer numerous daily activities, including exercise groups, art and craft classes, and singing. Staff are always present in each space and at each activity to support residents.

The first, Bluebell Care Home (pseudonym), is a large two-storey facility with 82 residents across the three low-, medium-, and high-care wards, including a specialist unit for residents with mid- and late-stage dementia. Despite doors/elevators with access codes between areas, residents are free to access all wards. Each floor has a large dining area, recreational areas with televisions, and several hallways leading to residents' private rooms. Most rooms are for single residents; all have an en-suite. The facility prides itself on creating a semi-luxurious, hotel-like atmosphere, with large garden areas and a popular on-site café at the front entrance.

The second, Rosewood Care Home (pseudonym), is a smaller single-storey facility in a lower socioeconomic area that housed 95 residents and has a separate locked wing for residents with dementia. The facility has a large hallway down its core, with dining areas at each end and branching hallways to residents' rooms. A number of residents' rooms are in the main hallway, which also has two lounge areas and a recreational area with a television. Private rooms with en-suites are available, however many rooms are shared between two residents. The facility has an outdoor pagoda and small garden.

Participants

Interviewees were aged 65+ and identified by facility staff as experiencing or being at risk of social isolation and/or loneliness. Residents unable to provide consent due to health reasons (e.g., cognitive impairments) were not interviewed. Because of the selection criteria, we relied on staff to recruit participants as we did not have access to residents' health records. Staff approached residents with an overview of the study; 22 agreed to participate. Researchers ensured their participation was voluntary, invited them to raise queries/concerns, and asked them to sign a consent form.

Age of interviewees ranged from 65 to 95 years; sixteen were female and six male. All participants resided in the care homes full-time. Table 1 includes additional socio-demographic information. Following an inclusive research practice, participants chose to select their pseudonyms (Allen & Wiles, 2016).

At the time of the interviews, seven participants reported feeling very lonely, eight sometimes lonely, and four lonely in the recent past (during ill health, loss of a relative, or prior to entering the care home). Three participants reported feeling isolated (two very, one sometimes) – one of these participants, Patricia, felt both very isolated and very lonely. Five (including the four who felt lonely recently) were at risk of social isolation and/or loneliness due to health decline, previous experiences, family loss, and mobility issues. As most participants focused mainly on loneliness, we might be underreporting social isolation. Nonetheless, we matched their perceptions and our field insights with the definitions of social isolation and loneliness advanced in the

Table 1
Participant Demographics.

Participant (Pseudonym)	Gender	Age	Marital status	Time at facility
Artie	M	91	Widowed	1 year
Audrey	F	65+ ^a	Widowed	1 year
Bill	M	94	Widowed	18 months
Charlie	M	86	Widowed	10 weeks
Ella	F	85	Widowed	3.5 years
Elsie	F	86	Single	Unknown
Gurney	M	90	Widowed	7 years
Isabelle	F	92	Widowed	1 year
Joanne	F	65	Single	10 years
Joe	M	87	Married	9 years
Kid	M	74	Widowed	3 years
Laura	F	65+ ^a	Widowed	“A few years”
Liz	F	84	Married	2 years, 2 months
Mary	F	88	Widowed	7 years
N	F	87	Widowed	2.5 years
Night Writer	F	78	Divorced	3 months
Patricia	F	79	Widowed	“Couple of years”
Pep	F	74	Widowed	4 years
Phyllis Diller	F	71	Divorced	1 year
Shoodoo	F	85	Widowed	4 years
Susan	F	95	Widowed	2 years
Wendy	F	79	Widowed	5 years

^a Participants confirmed that they were over 65, but preferred not to disclose specific age.

introduction. We found no major discrepancies between their experiences and the concepts under analysis, but our observations indicated that four of the seven participants who reported feeling very lonely were also socially isolated (Joanne, Gurney, Audrey, and Isabelle).

Data analysis

Field notes were digitised verbatim. Interviews were digitally recorded and transcribed verbatim. Thematic analysis was conducted to uncover themes and patterns describing loneliness and social isolation in later life, as captured by field notes and interviews (Fereday & Muir-Cochrane, 2006). We looked for themes within (individual) and across (collective) cases. Following Braun and Clarke's (2006) six steps to conduct thematic analysis, we: 1) read and re-read the transcripts and fieldnotes, getting acquainted with the data and observing initial ideas, 2) generated preliminary codes through a methodical analysis of the data, 3) combined codes into themes, 4) revised themes in relation to codes, extracts, quotes, and the whole dataset, producing a thematic diagram, 5) refined the themes, naming and defining each one, and 6) produced a report containing exemplar cases and linking themes with our research aim. First and second authors coded the data — first independently, then collectively to reach consensus on a final codebook. The coding process was both deductive and inductive – i.e., it included themes matching the interview questions and categories but also new information uncovered in the data (Fereday & Muir-Cochrane, 2006; King & Horrocks, 2010).

Findings

Within an interactionist and situationist approach, we bring together the interview and participant observation data to illustrate lived experiences of loneliness and social isolation in later life as well as to shed light on its agentic and structural dimensions. Although the care homes catered to different socioeconomic backgrounds – one seemed to have mostly high/middle-income residents, the other low/middle-income – we found no qualitative differences in how participants described loneliness and social isolation. Of the 22 interviewees, most reported experiencing persistent loneliness and some social isolation; two felt isolated-only; four had prior strong experiences of loneliness or social isolation because of family loss or health issues; and one did not

report loneliness or social isolation, but due to rapid health decline was identified by staff as at risk of both.

Experiences of loneliness and social isolation were captured in two overarching themes identified in the interviews: i) meanings and contexts and ii) coping and protective strategies (see Table 2 in the appendix for a complete list of themes and categories). The descriptions of these themes are complemented by contextual insights from our field observations, specifically in relation to three key dimensions: spatial-social-emotional environments, social activities, and institutionalization (see Table 3 in the appendix). These dimensions help contextualize the interview data and, drawing on a Goffmanian approach, expand on a situational understanding of what can influence or shape experiences of loneliness and social isolation among older people living in care homes.

Meanings and contexts of loneliness and social isolation

For most participants, loneliness and social isolation were perceived as the same negative phenomena. However, for some interviewees the former was a 'choice' while the latter an 'imposed condition'. Loneliness was seen as an individual action and choice: "you make yourself lonely", said Mary, or "you just shut down", offered Phyllis. Social isolation was perceived as a forced circumstance beyond the individual's control: "if you're isolated means that you want to be with people but you haven't got the possibility" (Mary); "you're just here on your own and nobody sees you or comes near you" (Patricia). Charlie was the only participant directly reporting social isolation but not loneliness; he had moved to the care home recently and was feeling isolated due to lack of friends and opportunities to make new acquaintances since "residents have dementia and cognitive problems" which "makes conversations very difficult". He also commented he had difficulty understanding some staff members' accents. Charlie still felt like a stranger, although he was trying to learn the norms, participate more often in the care home activities, and meet people: "if you don't participate you can be left out and feel isolated, so I participate in some of the things". His children visited frequently and took him out every Thursday, and friends from his prior retirement village visited monthly. Another interviewee, Joe, also faced some social isolation within the care home. Because of cognitive issues of other residents, he felt that, "you can't talk with anybody about things that you are interested in". He was not experiencing loneliness, as he had an active and meaningful social life outside the institution and visited his family residence twice weekly.

As a result of converging loneliness and social isolation, the majority of interviewees only defined loneliness. Loneliness was understood as: relational (loss of social ties), aging (age-related), personal troubles (personality traits or choices), and sickness (cognitive illness). Embedded in each is the idea that loneliness is both subjective (that is, based on personal experiences) and difficult to explain. For example, Gurney noted that, "I don't think there's an alternative description; I am lonely". Joanne further illustrated the difficulty of defining it, "You feel lonely and that inside you...". She did, however, engage in expressive body language to communicate a painful feeling. Wendy mentioned that, "It's something that until you experience it, it's hard to describe". Nonetheless, their descriptions and examples allowed us to identify a set of main definitions that represent their conceptions and experiences. These are not exclusive categories and closely inter-relate, as participants defined loneliness as more than one 'thing' – demonstrating its complexity and multidimensionality.

Loneliness as relational

According to most participants' accounts, loneliness related to a loss of close spousal and family ties and the absence of quality social relationships. As shown in Table 1, 16 of our participants had been widowed, and this loss of a close spousal tie informed their experience of

loneliness as relational. For example, Bill, who had lost his wife over a year prior, noted: "Your wife has been with you for that long – 72 years — you say to yourself, good God, who do I talk to now?" Likewise, Gurney expressed:

My wife died... that's what loneliness means... we were married something like 65 years, you know (...) Having a happy relationship, a good marriage (...) and we went together and her not being here together, that's loneliness.

Phyllis also noted that:

All my family's gone. I had to accept that. You see other people coming in with families. It does hurt. But you move on. You just move on, say, 'Well, they're lucky. Their family and that are still alive'.

Participants' experiences of loneliness as relational were also seen in their lack of or low social connectedness – wherein our older adults did not have access to meaningful social interaction, whether with a partner, children, broader family, friends, fellow residents, or staff. For instance, Audrey had lost all contact with friends since moving into the care home: "most of them don't know where I disappeared". Her only living family were her siblings, but her contact with them was very minimal. While she wished for greater contact, she explained that "they have their own things to do, in the sense they're working, they're busy with the home, they have their own lives – so I don't worry them". With regard to building connections in the home, Audrey felt that there was "no one to have a 'normal' conversation [with] (...) they [fellow residents] annoy me so much — it's like talking to the wall". The lack of social connections meant that many participants had no one to lean on for support. For example, Ella highlighted that for her, "loneliness is what I've got... nobody to talk to when I want to talk about things". Similarly, Charlie identified that loneliness for him means "you don't get attention from your friends or family, and you're just left to your own devices".

During our fieldwork, we observed contexts that add to this relational understanding of loneliness and its potential connection to social isolation, including norms, functions, and expectations regarding social interaction in different spaces within the care homes. For example, in addition to several public areas – from small reading spaces to a large dining area – Bluebell Care Home had a café with a fireplace and comfortable couches. This was the first public area encountered upon entering the facility, designed to give a sense of an external place (or of an 'open institution', contrasting with the sense of a total institution described by Goffman (1961)). Thus, residents congregated more in this area when they had visitors, particularly children and grandchildren. An outdoor area also offered a space for social interaction with visitors, who frequently used the space to share meals and snacks. These spaces seemed to serve three functions: to provide a non-care home feeling; to allow for privacy; and, as mentioned by several participants, to "protect" residents who didn't have visitors. The other public areas were mostly used by residents, who seemed to have an informally-allocated seat or place. When we would occupy a seat, a resident would quickly inform us of whom that place 'belonged' to. These strict yet unofficial rules regarding public spaces appeared to influence social interaction. On one hand, they allowed a group to continuously inhabit the same space, fostering conversations, relationships, and shared-silences. On the other, they precluded new interactions and routines from developing with other residents. Likewise, Rosewood Care Home had several small public spaces and a large dining area that served as a multi-purpose space for meals and activities. The first public area, with couches and a fireplace, was also mostly used by residents with visitors. Nonetheless, the café and outdoor area of Bluebell provided a sense of 'external' interactional space not found in Rosewood. Findings regarding 'visitor spaces' and informal spatial rules for residents were similar across the two care homes.

Loneliness as *oldering*

According to participants' accounts, aging and getting older (*oldering*) were associated with feelings of loneliness due to a variety of age-related circumstances. These circumstances included reminiscences of a younger past life, increased aged-care dependency, loss of mobility, increased frailty, institutionalization, feelings of broader social abandonment and rejection because of being old, reduced capacity to engage with others and in activities and occupations due to age-related frailty, loss of friends, and fear of making new friends and losing them. Patricia explained: "You end up losing all your friends. They're getting old like me. You don't see them so often. Your family don't bother with you so much because you're too old". Shoodoo mentioned that "you have friends and they pass and you don't get them back". Joe indicated that the two residents he was closed to within the home passed away: "I must be a jinx". Other interviewees indicated the same; Isabelle said she is trying to stop making friends among the residents as three friends living in the home recently passed away: "I seem to have the kiss of death".

This theme also draws on participants' perceptions of the "sick oldie" (Gurney) and internalized age and frailty-based norms and expectations. Most interviewees underlined a connection between later life, loneliness, and institutionalization. As N noted, at her late life stage, "only the nurse come and give me injections (...) who cares?". Likewise, Audrey described that due to being old and in a care home: "there's nobody to talk to (...) no normal people, just the tea lady and the kitchen staff". Other participants echoed those feelings, particularly regarding their decreased social value because of aging and frailty. Isabelle emotionally conveyed that loneliness in old age is feeling:

Miserable and unwanted. Forgotten (...) just that no one gives a damn if you're alive or dead... which is wrong because I know my daughter and son care for me a lot, and they'd probably be hurt if they heard me say that, but they've got their own lives to live, unfortunately, and they are very busy lives, which doesn't leave much time to visit mum – me.

Finally, loss of independence and lack of control of their lives were other major dimensions of 'oldering'. For example, for Kid, loneliness was an awareness of age limitations – of not being able to do the activities he once was engaged with because of ill health and institutionalization. His stroke and entering the care home enhanced that awareness:

You compare the difference. I've pondered over how old I am. I've sat in the wheelchair and I, I stare at someone, or I stare outside or look for a bird or something, fly by. Because when you're seventy-four, you can't turn the time back. You can't turn the time back, so you've got to say young thoughts to keep yourself young. But it's here [emphasis; indicates to head].

Living in an aged-care institution provides particular contexts that can interplay with the relational and *oldering* meanings described above. In our field observations, we noticed that while the care home gave residents a sense of safety and personal and social routine (e.g., marked by meal times and activities), it also led to boredom, monotony, dependency, and a lack of relationships. During our fieldwork, several residents would approach us daily to share their opinions on life, current affairs, politics, the weather, or just to sit next to us. One male resident in his 90s told us that he felt safe at the home and enjoyed the routine (having a bed, meals, and people around), but simultaneously struggled with the routinization, namely of being at the care home all day, doing the same things, and with no option to leave. Although we did not talk to him directly about loneliness, he mentioned: "life is people; we need to belong; we need to talk, we old lonely men (...) we see each other every day, but we don't talk, we don't even know what to do". Other residents shared similar views regarding the positive and negative aspects of institutionalization, particularly in terms of social

relationships: from the advantage of having dedicated staff to the disadvantage of losing frequent contact with family and friends once entering residential care.

Loneliness as *personal troubles*

This theme captures participants' understandings of loneliness as associated with personality traits, self-imposed choices, and feelings of selfishness and guilt. Personality traits relate to "being introverted" (Elsie) or "not having made enough friends" (Patricia). Self-imposed choices convey that individuals were choosing to feel and/or remain lonely, despite knowing how debilitating loneliness could be. Shoodoo said:

Loneliness is devastating. It's the worst bloody feeling in the world (...) you feel like (...) no one loves you and they actually do, but in your head and your heart you think 'no one gives a damn if I'm alive or dead'. A lot of people make the loneliness by themselves on their own, in their heads.

Several other interviewees emphasized personal responsibility for experiencing loneliness, from not being "good at making friends" (Elsie) to not being capable "to get out of the dumps sometimes" (Joanne). Consequently, self-proclaimed selfishness and guilt arose because some participants felt that compared to other residents, they weren't as frail and still had some social contact, so had no justifiable reason to feel lonely. Thus, experiencing loneliness was self-centred: "I wish I had it all again, and I know that's selfish (...) I'm very lucky, some people don't get visitors at all" (Liz). Interviewees' experiences of loneliness reflected C. Wright Mills' (1959) conceptualisation of 'personal troubles', which are personal challenges or private problems faced by a person and their close networks. Although these seem personal, they are shaped by social contexts.

Loneliness as *sickness*

Loneliness was also seen by participants as ill emotional and cognitive health. For example, according to Artie, loneliness is "the most frightening disease in the world (...) you know when you get depressed? Well, multiply that by a couple more". Additionally, many participants saw loneliness as a particular cognitive mindset; something you can change by, as explained by Artie, "framing things differently". Psychology was a recurrent idea – a belief that feelings of loneliness were simply in the individual's psyche and that they had the power to change it on their own. For instance, Liz often mentioned that when lonely, "I just stop, and I think, 'well, it's time to go down for dinner or lunch or whatever'" – as though she could fully control her loneliness.

In sum, these meanings and understandings highlight the interconnection of agentic and structural issues in experiences of loneliness and social isolation among frail older people living in care homes. In addition, we can note a tension between seeing these phenomena as relational and collective (based on social relationships, age-related norms, and expectations) and as personal and individual.

Coping and *protective strategies*

Although many of our interviewees felt debilitated and would sometimes "shut down" when facing loneliness and social isolation, most shared their ways of living through and dealing with these feelings. These strategies were both individual and social, and predominantly based on "doing something" (Kid). For instance, Pep explained she would "shake myself [and] say, 'come on, let's do something'". Individual strategies included "getting distracted" by activities to occupy one's mind, such as "going for a walk" (Pep, Susan, Gurney, Laura, Isabelle, N), "looking out the window" (Patricia), or doing "something enjoyable" such as art, colouring, listening to music, watching TV, reading, doing puzzles, praying, and cleaning (Kid, Artie,

Bill, Charlie, Elsie, Laura, Pep, N, Gurney, Ella, Audrey). For Susan, Audrey and Ella, “having a little cry” was seen as a result of loneliness but also a way of releasing tension.

Social strategies, put in place by most of the interviewees, represented attempts to address relational aspects of loneliness by involving others, such as talking to family, staff, or residents. In fact, as noted through the field observation, the social environment of the research sites were framed by three groups of actors or agents: staff, residents, and visitors. In both Bluebell and Rosewood, staff were extremely busy. ‘Lifestyle managers’ – i.e., staff responsible for social activities and the socio-emotional well-being of residents – interacted constantly with residents, even if just to acknowledge their presence. In particular, they would hug and kiss residents in a caring rather than clinical way, contrasting with the medical staff. Residents in Rosewood and Bluebell displayed low levels of social interaction among themselves, rarely interacting during meals, in public spaces, or during activities. In both the interviews and our observations, several residents engaged in ‘othering’ – highlighting the differences between themselves and fellow residents (seen as ‘strangers’). The existing pockets of interaction were among small groups and mainly based on sociocultural composition, such as shared language. In both homes, a few residents would act as ‘bridges’, engaging with other residents and trying to establish cross-interaction between them. Sharing silences also seemed to play an important social action when it occurred within groups of close residents, as it demarcated company and comfort. Finally, visitors brought some excitement and conversation topics to care home routines. Staff members also identified ‘seasons of connection’, such as birthdays or religious holidays, when visitor numbers would increase and facilitate higher levels of social interaction.

These contexts and participants' strategies closely intertwined. For instance, the interview data highlighted that: i) participants' need to talk was shaped by efforts to regulate their feelings and expressions in a way that would not be harmful to and burdensome for others; ii) they had to self-manage the stigma associated with disclosing experiences of loneliness and social isolation; and iii) they had to grapple with responses that ignored or minimized negative emotions or with not having people available for their social needs. Patricia confided about not talking about loneliness and isolation with others even when she needs to, because “I don't want them to be feeling miserable too, do I?”. Audrey also shared that she needs to talk, but “whom can you talk to?”. Elsie added that it is hard because of the shame it entails. Gurney noted that he tried to talk to staff and other residents, but that “no one wants to hear about it”. Furthermore, several participants reiterated that other residents have cognitive impairments, which makes it hard for them to have conversations: “there's not a lot of people you can communicate with (...) because of the dementia” (Pep). Concurrently, the fieldwork data indicated that the emotional environment of the care homes was marked by two central trends in both facilities. Firstly, there seemed to be no formal or informal space or time to discuss or process negative emotions; we observed that when residents shared feelings of loneliness, staff would redirect the conversation to emphasize positive elements, such as the weather: “oh, but look outside, it's such a beautiful day”. This was also reported by several participants. For example, Gurney mentioned that he was constantly being dismissed when he wanted to talk to staff and other residents about loneliness as they would change the topic and try to re-focus his attention on “positive things”. Secondly, the playfulness and positivity of staff, especially lifestyle managers, seemed to serve a range of functions, including anticipating and preventing negative feelings. Related to both social strategies and immediate contexts are understandings of loneliness as *oldering*: as noted by many interviewees, being old and frail meant not only being more susceptible to loneliness and isolation but also having to deal with a lack of agency and with the social stigma associated with those statuses. In particular, loneliness carried a considerable stigma for our participants, which shaped how they dealt with it, the strategies that some had devised to manage it, or the resignation to embrace it as

an individual issue.

Another social strategy, mentioned by several participants, was to directly focus on other residents rather than on their own feelings, because some residents were ‘more’ vulnerable and lonely: “I talk to everyone, I kiss everyone (...) I feel so sad for some of these people (...) they don't have carers”, explained Liz. This could be seen as an attempt to tackle loneliness as ‘personal troubles’, as by focusing on others' conditions we can offset one's personality traits or feelings of selfishness, as stated by Liz. However, as noted in our field observation, it could also be a way of combating the social stigma of loneliness and isolation – by focusing on others who potentially experience the same, one can simultaneously help others, raise awareness of isolation and loneliness, and benefit from a more open or compassionate environment.

Engaging in internal social activities, such as physical exercise, craft, and music sessions, was indicated by a few interviewees as an additional social strategy used to open conversations and enhance social involvement. Yet, these activities seemed predominantly individual, even if in a group setting. For example, during weekly art and craft classes, a group of residents would sit together, drawing with a teacher, but focusing only on their individual drawing without engaging in conversations. The same was observed with music sessions, where residents sang together but did not talk or look at each other – even if in Bluebell these were described as “therapy for socio-emotional connectedness”. The literature does emphasize the important role of art and music for emotional and social well-being (Zeltzer, Stanley, Melo, & LaPorte, 2003); however, the sessions we observed could have focused more on social interaction among residents and on discussion about feelings and contexts. When there was any verbal and non-verbal interaction in the exercise, art, and music sessions, it was between the teacher and a resident, but rarely between residents. In Rosewood, some residents were also wheeled to/from activities without any agency. We heard residents asking the staff where they were going and why. To enhance inclusion, this facility would bring together residents with different levels of frailty. This meant that not all were able to participate equally in the activities – for example, some would be sleeping during the sessions. While this attempt seemed to give residents a sense of social involvement, it could also be facilitating ‘othering’ and creating tension between those who were able to participate and those who were not, therefore reinforcing both inclusion and exclusion. Because of frailty, the end of activities represented limbo moments for some of Rosewood residents as they waited to be wheeled away by the staff. In these moments, most residents would refrain from engaging with others by displaying a gaze of avoidance; they would look down at their hands or avoid making eye contact with others. Nonetheless, the few small close groups would briefly communicate during this limbo period.

Only a few interviewees discussed protective strategies (activities they would engage in to prevent experiences of loneliness and social isolation): making friends at the home (Pep), having a well-defined routine with walks (Susan, Liz, Laura), accepting their situation (Phyllis), and building resilience (Phyllis). These demonstrate, once again, an individual responsibility to address loneliness and social isolation.

Taken together, strategies to live through, cope with, or manage their loneliness and/or isolation are closely linked to participants' meanings and definitions of the phenomena. Thus, we can further observe the strain between agentic and structural dimensions but also the constraints and options of encompassing living settings, such as care homes, characterized by social standardization and routinization.

Discussion

Loneliness and social isolation were perceived by our participants as synonymous with negative experiences. Some interviewees distinguished between loneliness and social isolation: the former was a

choice, whereas the latter an imposed circumstance characterized by lack of relationships or support. Contrary to some prior findings, our participants saw social isolation as harmful and beyond their control (Cloutier-Fisher et al., 2011). Also contrasting with Stanley et al.'s study (2010), most interviewees equated loneliness with social isolation — even though, conceptually and analytically, they mean different things and are measured differently. These differences might be due to our focus on frail older people living in care homes rather than living in the community, or cultural idiosyncrasies.

Generally, loneliness and social isolation were seen as relational, i.e., linked to loss of close relatives or lack of quality relationships — as also shown in the scarce literature on the subject (McHugh et al., 2017; Schoenmakers & Tindemans, 2017; Stanley et al., 2010). They were also associated with aging (age-related contexts, norms, and status), personal troubles (personality, self-imposed decisions), and sickness (emotional and cognitive illness). Hence, structural and agentic elements interplayed. For instance, the use of Mills' (1959) 'personal troubles' emphasized how an agentic understanding of loneliness also draws on and shapes structural issues (or 'public troubles' in Mills' words). Therefore, a comprehensive approach to loneliness must study the relationship between agentic and structural dimensions. The interview and field observation data illustrated this interaction and the importance of contexts: loneliness and social isolation are not merely an individual trouble, nor are they just a social issue; they are both.

These new and rich understandings situate loneliness and social isolation as multidimensional phenomena: on the one hand, for example, related to aging as a structural dimension; on the other, resting on an agentic dimension, perceived by interviewees as individual fault or responsibility (e.g., of not making friends or wanting to burden families). Connected to the agentic dimension is seeing loneliness and social isolation as private matters, subjective, and hard to talk about (Schoenmakers & Tindemans, 2017; Stanley et al., 2010). Perceiving these phenomena as individual fault or responsibility explains the stigma, pain, shame, and guilt reported by participants (McHugh et al., 2017; McInnis & White, 2001). It also explains why, despite the structural understandings of the phenomena, most participants still saw it as their responsibility to address it.

But despite the stigma associated with loneliness and social isolation (and its potentially debilitating effects that could lead to 'shutting down'), most interviewees engaged in individual or social strategies to manage them. As found in Azeredo and Afonso (2016) and McInnis and White's (2001) studies, our participants prioritised doing activities — from going for walks to talking to more vulnerable residents — as a means of addressing loneliness. Although a minority of interviewees mentioned protective strategies such as having a routine, solitude was not mentioned as protecting against loneliness, as in McHugh et al.'s research (2017). What was clear in the strategies of our interviewees was a strong connection between their understandings of loneliness (as relational, aging, personal troubles, and sickness) and their attempts to deal with it within standardized living settings. For example, understandings of loneliness as relational led to conversational efforts or attempts with different agents in the care home (primarily staff and visitors). Loneliness as a result of an aging process directed participants to adjusting their actions to an aged-care environment by following rules and expectations and continuously self-managing stigmatizing conditions or responses. For instance, several participants emphasized how being "old" — and, as a consequence, "frail" — not only made them more vulnerable to loneliness and isolation, as it complicated their opportunities to address them (e.g., being dismissed or patronized). Loneliness as personal troubles meant that it was one's responsibility to cope with it. Helping other residents (older, more frail, and with no family support) also added to this understanding (and potentially to aging assumptions). Loneliness as sickness involved notions of individual responsibility and the pressure to or deal with it or resign to its effects.

Strategies were also adjusted to participants' contexts, as living in

care institutions influenced social interaction and their experiences of loneliness and isolation (Goffman, 1961; Gubrium & Holstein, 2016). Our findings evince the lack of opportunities within participants' spatial-social-emotional environments to talk and process experiences of loneliness and social isolation, as attempts were brushed aside by staff, family, and even other residents, reinforcing stigma and embarrassment. These different environments shaped social microcosms (Brossard, 2016), characterized by norms and expectations regarding social interaction between residents, staff, and visitors. For example, the social activities offered by the care homes illustrated the tensions between the informally-forced collective life and the individualization of social activities. In fact, some activities seemed to inhibit rather than facilitate social connectedness due to their individualized or standardized (one-size-fits-all) delivery — as also noted by Bergland and Kirkevold (2008) and Bland (2007). Nonetheless, strategies reported by participants and observed during fieldwork drew on these circumstances: engaging in social activities was encouraged by staff and family, while disclosing, negatively reacting to (e.g., having a cry), or discussing their loneliness was ignored or re-directed to a conversation about other, more positive, topics.

Because of the need and pressure to follow these 'house rules' (Goffman, 1961), self-presentation and impression management (Goffman, 1967) were common among participants — through, for instance, efforts to maintain a sense of self and identity while avoiding being seen by others as a "burden" and further stigmatizing themselves (in what Goffman would describe as the gap between one's actual social identity and their virtual social identity). Also evident was the constant tension between sense of self and emotional and social needs. Living in a total institution (Goffman, 1961) contributed different layers to self-presentation and social interaction — notably, efforts to both engage in "interactional citizenship" (Colomy & Brown, 1996; Goffman, 1967) and preserve "civil inattention" (Goffman, 1972). This meant being a good citizen of the care home by participating in activities, respecting the social expectations of the different spaces, and upholding the 'house rules' (Goffman, 1961), while knowing when to maintain neutral interaction (e.g., gaze of avoidance) to respect others' privacy and protect one's own. Our research supports Paque et al.'s (2018) findings that losing self-determination due to institutionalization relates to loneliness. However, institutionalization was linked to both positive and negative outcomes in terms of social connectedness, influencing experiences of loneliness and social isolation. On the one hand, professional staff meant adequate care and new social ties; on the other, living in a care home meant missing out on regular contact with relatives and friends, dependency, routinization, and a compromised sense of self and identity.

As a result, we observed continuous emotion work (Hochschild, 1979) in the accounts of our interviewees and during field observations. The data illustrated how feelings of selfishness and guilt were coupled with loneliness, and how participants' need to talk to others about their experiences of loneliness and isolation was closely self-managed to avoid being seen as a burden, evade stigmatization, and cope with being ignored or made feel 'needy' or irrelevant. We saw all three emotion work techniques described by Hochschild at play: cognitive emotion work in how participants would describe their attempts to change their thoughts about loneliness and get distracted by other things; bodily emotion work in efforts to control their physical reactions in public; and expressive emotion work based on their individual and social strategies to change gestures and dispositions (Hochschild, 1979). In this context, their techniques operated in a constant negotiation between feeling rules (what they should feel) and emotion work (what they should try to feel) within particular circumstances (Hochschild, 1979). Latent to these concepts are ideas of social control of encompassing institutions — from controlling interaction to constraining emotional display.

The spatial-socio-emotional environments of the care homes lent further evidence to this negotiation and to the emotion work required

by residents (but also staff and visitors). The social rules and expectations of the care homes and of the different agents inhabiting that space shaped both experiences of loneliness and isolation among our participants and how they lived through it. For example, the need to protect more vulnerable and isolated residents from seeing other residents' family or friends illustrates a constant individual and collective emotion management. Caring for other residents as a coping strategy for one's own loneliness and isolation can be also seen as part of that emotion work and signify symbolic capital in the community – i.e., being seen as a valued member and citizen. This relates to the 'interactional citizenship' need and pressure of encompassing institutions, especially if the social 'house rules and privileges' are taken into account (Colomy & Brown, 1996; Goffman, 1967).

Moreover, the emotional labor from staff – visible in the recurrent smiling and positivity efforts – was simultaneously interacting with the emotion work of residents (Hochschild, 1979). Care homes are a combination of private and public spaces, where non-paid (residents, visitors) and paid agents (staff) interact. Both emotional labor and emotion work seemed embedded in these total institutions, with different but interacting meanings. While the staff's emotional positivity can prevent or reduce discussions about loneliness and isolation, the residents' emotion work led to strategies adjusted to their particular contexts such as efforts to regulate their feelings and self-manage the stigma associated with not only loneliness and isolation but also aging and frailty. The Hochschildian perspective also helps deconstruct assumptions of lonely and socially isolated older adults as passive. Our results show they are involved in managing their experiences, even if not always successfully. Emotion work, for instance, relates to the attempt to change or manage emotion, not the result. The emotion work concept further draws attention to the connection between agency and structure, since emotions are affected by social rules and guidelines about what to and how to feel – which in turn, illustrate social conventions and tensions between personal experiences and social expectations (Hochschild, 1979).

Conclusion

This article contributes a detailed understanding of the lived experience of loneliness and social isolation among frail older people living in care homes by drawing on a sociological lens that explores interactionist approaches and structural and agentic dimensions (Goffman, 1967; Hochschild, 1979). Although participants describe and situate experiences of loneliness and social isolation within both agentic and structural dimensions, most saw the phenomena as an individual responsibility. This meant that they had to deal with these experiences through the individual and social strategies they had devised. Yet, because of the social nature of the phenomena, life stage, and living settings, their loneliness and isolation – including management and coping strategies – were framed by their contexts. These contexts included:

Appendix A

Table 2
Interview themes.

Meanings & definitions	Coping strategies	Protective strategies
Loneliness as: <ul style="list-style-type: none"> ■ Relational ■ Oldering ■ Personal troubles ■ Sickness Social Isolation as: <ul style="list-style-type: none"> ■ Imposed by context 	Individual coping strategies: <ul style="list-style-type: none"> ■ 'Getting distracted' by activities, e.g., walks, art and craft, watching TV, or reading Social coping strategies: <ul style="list-style-type: none"> ■ Talking to others ■ Helping more vulnerable residents 	<ul style="list-style-type: none"> ■ Making friends ■ Routine ■ Acceptance ■ Building resilience

rules and expectations about social interaction and emotional display in later life; a lack of opportunities to discuss loneliness or isolation in their living settings; and the stigmatization of these experiences as staff, family/carers, or other residents prevented their disclosure or made them irrelevant. Perceptions of oldering (getting older and frail), for instance, seemed to make participants more likely to experience loneliness and isolation but also made it harder for them to tackle those experiences within their living and social circumstances. Because of all these circumstances, participants engaged in self-regulation of their interactions and expressions of loneliness and isolation to avoid stigma or being burdensome to others.

Findings shed further light on related negative but also positive dimensions of living in aged-care institutions. Routinization, alienation from other residents (othering, being 'alone together'), individualization (even in social activities), and not sharing and processing negative feelings seemed to represent loneliness and isolation risks. Staff's engagement, human touch and presence, and residents who acted as social 'bridges' seemed important protective and coping strategies for loneliness and social isolation. In particular, creating opportunities for social connectedness, i.e., meaningful social relationships (quality, not quantity) and destigmatizing loneliness and isolation seem crucial to both alleviate and protect from these issues. This is critical knowledge to inform researchers, practitioners, and interventions.

While this research is limited by a convenience sample and cross-sectional interviews, our work adds to a richer understanding of loneliness and social isolation among older people living in institutional settings. It builds on a sociological perspective to loneliness and isolation in later life that also contributes to the existing psychological and existential perspectives by tapping into emotional issues, oldering dynamics, and coping strategies. To our knowledge, this is a first attempt to combine Goffman (1959, 1961, 1967, 1972) and Hochschild (1979, 1983) approaches to analyze loneliness and social isolation among older people. We show its relevance and value in the understanding of complex psychosocial phenomena and in fleshing out critical social contexts. Future studies could expand on these approaches as well as consider a qualitative longitudinal design to ensure a deeper exploration of participants' contexts over time.

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Table 3
Field notes themes.

	Spatial-social-emotional environments	Social activities	Institutionalization
+	<ul style="list-style-type: none"> ■ Social norms enhancing existing relationships ■ Lifestyle managers ■ Residents acting as ‘bridges’ ■ Positivity of staff 	<ul style="list-style-type: none"> ■ Diverse activities (e.g., physical exercise, art and craft, music) 	<ul style="list-style-type: none"> ■ Safety ■ Professional care ■ Routine
–	<ul style="list-style-type: none"> ■ Social norms precluding new relationships ■ Othering ■ No space/time to discuss negative feelings such as loneliness 	<ul style="list-style-type: none"> ■ Individualization ■ Most interaction teacher-resident, not between residents ■ Inclusion vs. exclusion ■ Limbo moments 	<ul style="list-style-type: none"> ■ Boredom ■ Dependency ■ Decrease of family interaction ■ Lack of social connectedness

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