# A Comparison of Loneliness and Social Support among South African Older Persons during a Pandemic

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## Abstract

Pandemics, such as the outbreak of the novel coronavirus (Covid-19) in March 2020, have a negative impact on older persons' (60 years and older) physical and mental health. Research on the effects of Covid-19 on older persons' experience of loneliness and self-reported social support has predominately originated from the Global North. Applying the strengths perspective, the present study aimed to determine and compare the loneliness and social support among South African older persons during a pandemic. A cross-sectional survey was operationalised to collect data from community-dwelling older persons ($n = 139$) and older persons residing in residential care facilities ($n = 99$) through purposive sampling across five South African provinces. A loneliness scale was used to measure the respondents' overall loneliness, including emotional and social loneliness. A social support scale was used to measure the availability of social support across four domains. The survey focused on social contact, number of close friends/relatives, socio-demographics, and subjective physical and mental health, respectively. Independent samples *t*-tests were run to explore any statistically significant differences between the two groups. Community-dwelling older persons were found to present with marginally higher levels of loneliness. No statistically significant differences were identified between the two groups. Community-dwelling older persons measured higher on social support than their peers in residential care. Two domains of social support, namely, affectionate support and positive social interaction, were found to be significantly different ($p < 0.01$). Based on the study's results, implications for strengths-based gerontological social work services in resource-constrained settings during a pandemic were delineated.

**Keywords:** loneliness; social support; older persons; pandemic; strengths perspective; gerontological social work

## Introduction

Pandemics, such as the outbreak of the novel coronavirus (Covid-19) in March 2020, are to be expected as a consequence of climate change and an increasing world population (Siddiqui et al. 2022). Older persons' (60 years and older) physical and mental health are particularly vulnerable during pandemics (Savci et al. 2021).

In South Africa, the research site of the present study, the government announced a state of emergency and implemented among the strictest alert systems (e.g. lockdown measures) in the world on 26 March 2020 to manage the Covid-19 pandemic (WHO 2021). The five-level lockdown measures included, amongst others, physical distancing, compulsory wearing of face masks, stay-at-home restrictions, and a ban on social gatherings, including funerals and other grief practices (WHO 2021). The impact of the lockdown measures was extreme for older persons as government advisors often did not consider their unique circumstances (Payne 2022). For example, community-based social services (e.g. luncheon clubs) were suspended; the health system favoured the admittance of younger persons to intensive care units; reports of the financial abuse of older persons increased; while older persons in residential care were prohibited from receiving visitors (WHO 2021). Approximately 9.2% (±5.58 million) of the 60.6 million citizens of South Africa are older persons (Stats SA 2023a). Despite vaccinations being available for older persons since February 2021, 569 700 older persons tested positive for Covid-19 and an estimated 85 000 died as a result of Covid-19 related conditions (Department of Health 2023; Stent 2021).

The Covid-19 pandemic, coupled with strict lockdown measures, had a distinct impact on the well-being (in the present study referring to the experience of loneliness and self-reported levels of social support) of older persons. On a psycho-social level, older persons experienced increased levels of anxiety, emotional exhaustion, fear, loneliness, interpersonal conflict and stress, along with limited social support (Gao, Mosazadeh and Nazari 2023; Onal et al. 2022). On a physical level, older persons presented with cardiovascular disease, a decline in cognitive behaviour as a result of isolation, lower immunity, increased mortality, as well as suicidality and psychopathology due to loneliness and lack of social support (Gao, Mosazadeh and Nazari 2023; Onal et al. 2022; Teater, Chonody and Hannan 2021). From the extant literature, it would appear that the mentioned impacts were amongst the most severe for older persons in residential care (e.g. Gao, Mosazadeh and Nazari 2023; Huber and Seifert 2022).

The authors consulted several research databases (i.e. PsycINFO, Sabinet African Journals, Science Direct, Social Work Abstracts, Springer Link, and Taylor and Francis Journals) and identified a few studies that determined and/or compared the levels of loneliness (using the 6- or 11-item loneliness scale of De Jong-Gierveld and Kamphuis (1985)) among community-dwelling older persons and those in residential care during Covid-19 in the Global North. However, a hiatus was identified as it pertained to a comparative study focusing on loneliness among older persons in the Global South, such as South Africa. Equally, no studies were identified that explored the self-reported levels of social support among older persons during Covid-19 with a standardised instrument, such as the Medical Outcomes Study (MOS) Social Support Survey (Sherbourne and Stewart 1991).

Bearing these hiatuses in mind, the present study aimed to compare loneliness and social support, respectively, among South African older persons living in communities and in residential care during the Covid-19 pandemic. The following research questions guided the study:

1. What is the level of social loneliness, emotional loneliness, overall loneliness, and self-reported levels of social support (emotional/informational; tangible; affectionate; positive social interaction; overall social support) among community-dwelling older persons and older persons residing in residential care facilities during Covid-19?
2. Is there a statistically significant difference in levels of loneliness and self-reported social support between community-dwelling older persons versus older persons residing in residential care facilities during Covid-19?

## Synoptic Literature Overview

### Loneliness

Loneliness has a detrimental impact on the well-being of older persons. At the most basic level, loneliness could be defined as "the unpleasant experience that occurs when a person's network of social relations is deficient in some important way" (Van Tilburg 2022, e179–e180). Two dimensions of loneliness were considered to be of importance in the study, namely: "emotional loneliness" is experienced when an older person feels that the quality of relationships or required intimacy is not met, whereas "social loneliness" is a lack of connectedness to a group or network of people (Wong et al. 2022). Pandemics, such as Covid-19, have been found to make older persons vulnerable to increased levels of loneliness as the lockdown measures have an impact on the permitted quantity and quality of contact with significant others, and a ban on social groups and participation in social events (Gao, Mosazadeh and Nazari 2023; Van Tilburg 2022).

Van Tilburg (2022) refers to numerous studies in the Global North (e.g. Norway, the Netherlands, Switzerland, and the United States [US]), that found loneliness increased among older persons during Covid-19. Sepúlveda-Loyola et al. (2020) make similar observations in a multi-national study among older persons in Asia, Europe and the US. It is important to note that, in contrast to community-dwelling older persons, higher levels of loneliness were measured among older persons in residential care in Canada, Iran, Switzerland and Turkey (Gao, Mosazadeh and Nazari 2023; Huber and Seifert 2022; Savci et al. 2021; Wong et al. 2022).

**Social Support**

Social support could be considered a strength in the life of older persons with the potential to improve their physical and mental health (Vlachantoni et al. 2022), especially during times of crises such as Covid-19 (Oryan et al. 2023). In the present study, social support is considered a multi-dimensional construct. Sherbourne and Stewart (1991) identify the following four domains of social support:

1. **Emotional/Informational support** refers to the experience of care, empathy, encouragement, and receiving guidance/feedback when dealing with difficult situations.
2. **Tangible support** signals the availability of material aid and behavioural assistance.
3. **Affectionate support** is associated with circumstances where love and affection can be received and expressed.
4. **Positive social interaction** refers to the availability of people and connections to spend time and share recreational activities.

The extant literature reported that lockdown measures negatively impacted the available social support to older persons. The negative impact of declined social support has been confirmed in studies in Canada and the United Kingdom (UK) (Menec et al. 2020; Vlachantoni et al. 2022).

## Theoretical Framework

The study was underpinned by the strengths perspective, thus there was a departure from a pathogenic to a salutogenic approach (Van Breda 2019). Challenges and problems of people are not ignored; rather the emphasis is on people's abilities, resources and strengths (Kondrat 2020).

The strengths perspective has been used in a variety of settings and with diverse service users. It is especially appropriate for gerontological social work (McInnis-Dittrich 2014). The social worker and older persons come together as equal partners to identify strengths and resources within the self and the environment. These are then innovatively activated through implementing the primary methods of social work to journey with older persons to a point where they experience empowerment and achieve outcomes that are meaningful to them amidst a pandemic (Nelson-Becker et al. 2020).

## Research Methodology

### Research Approach and Design

A quantitative research approach was operationalised through a cross-sectional survey design, which enabled the authors to collect data from both community-dwelling older persons and those residing in residential care facilities during a pandemic (Babbie 2021).

## Setting and Sampling

The present study was conducted in South Africa. A total of 139 community-dwelling older persons and a total of 99 older persons residing in private residential care facilities participated in the study. Community-dwelling older persons were recruited through indirect purposive sampling across five of the nine provinces (i.e. Gauteng, KwaZulu-Natal, Mpumalanga, North West, and Limpopo) of South Africa. To protect the identity and privacy of potential respondents, and to comply with Covid-19 lockdown measures, the first author wrote a letter of invitation with a link to an online Qualtrics™ survey to two organisations; a welfare organisation and a service centre for older persons. The two organisations distributed the invitation via e-mail on three occasions to older persons who were either volunteers at the welfare organisation or were service users of the service centre. The data was collected during 2021 with Levels 2, 3 and 4 Covid-19 lockdown measures in place. The inclusion criteria for community-dwelling older persons were as follows: (a) they had to be on the e-mail database of the two welfare organisations; (b) they had to be aged 60 years and older; (c) they had to have access to a computer or smartphone with adequate data to complete the online survey; (d) they had to be able to read and write either English or Afrikaans (two of the official languages of South Africa); and (e) they had to offer informed consent on the online system before obtaining access to the survey.

The sampling of older persons in residential care required another sampling strategy as they are often frail and less likely to possess the devices and skills to complete online surveys. One welfare organisation in Gauteng was purposively selected with a request to conduct face-to-face surveys with older persons at five of its residential care facilities. The first author was in contact with the social workers at each residential facility with information about the aim of the study, procedures and inclusion criteria. The social workers recruited potential respondents. Only those who indicated an interest were brought in contact with the first author. The data was collected during 2022 with Level 1 Covid-19 lockdown measures in place. Thus, distanced interviewing with face masks was allowed. The inclusion criteria for older persons in residential care were as follows: (a) they had to be 60 years and older and living in a residential care facility during Covid-19; (b) they had to be able to converse in English; and (c) they had to offer voluntary written informed consent. In both instances, older persons living with a form of dementia were excluded from the study.

### Data Collection

The same questionnaire was used for both groups. The only difference was whether it was completed online or through face-to-face surveys (Babbie 2021). Face-to-face surveys were conducted by trained field workers. The survey consisted of items that determined loneliness, social support, types of social contact (e.g. face-to-face;

online/virtual; groups/organisations), number of close friends/relatives, and socio-demographics of age, gender, home language, area of residence, province, highest qualification, employment status, relationship status, living arrangements, number of children, and religious or spiritual beliefs. The respondents were also asked to rate their subjective physical health and subjective mental health.

*Independent Variable*

The independent variable in the study was the residential status of the respondents who consisted of community-dwelling older persons and those residing in residential care facilities.

*Dependent Variables*

The loneliness scale of De Jong-Gierveld and Kamphuis (1985), which is a standardised instrument in the public domain, was used to measure the dependent variable of loneliness. Apart from overall loneliness, the scale measures two sub-scales, namely social loneliness and emotional loneliness. The 11-item instrument consists of five statements on social loneliness (e.g. "There are plenty of people I can rely on when I have problems") and six statements on emotional loneliness (e.g. "I miss having a really close friend"). The scale asks the respondents to indicate the extent to which they agree with the statements (1 = Strongly disagree – 6 = Strongly agree). After reverse scoring the five social loneliness items, the response to each item is summed to produce an overall loneliness score (11–66) with higher scores indicating higher levels of loneliness. Additionally, the six items on emotional loneliness can be summed to produce an overall emotional loneliness score (6–36), and the five items on social loneliness can be summed to produce an overall social loneliness score (5–30). Lower scores signal less loneliness experienced. For the present study, if a respondent scored one or more missing values, the particular respondent was deleted from the analysis. The Cronbach's alpha indicated a very good level of internal consistency (reliability) across the subscales with values ranging from .82 – .89 (cf. Field 2013).

Social support was measured using the MOS Social Support Survey (Sherbourne and Stewart 1991), also a standardised instrument in the public domain. It measures the availability of support across four domains and a total social support score. The instrument asks, "How often was each of the following kinds of support available to you if you needed it?" and then lists 19 statements. Eight statements measure emotional/informational support (e.g. "Someone you can count on to listen to you when you need to talk"); four statements measure tangible support (e.g. "Someone to take you to the doctor if you needed it"); three statements measure affectionate support (e.g. "Someone who hugs you"); and three statements measure positive social interaction (e.g. "Someone to get together with for relaxation"). The scale asks the respondents to indicate how often each of the supports is available to them (1 = Never – 5 = Always). Mean scores are calculated for each of the four subscales and the overall scale with higher scores indicating higher support. Finally, the means of the four subscales and overall scale are transformed into a 0–100 scale with higher scores indicating higher social support. For the present study, if a respondent had at least one valid response on any subscale, then they were included in the analysis of the individual subscales (Sherbourne and Stewart 1991). The Cronbach's alpha indicated a high level of internal consistency (reliability) in the study across the subscales with values ranging from .73 – .98 (cf. Field 2013).

Three types of social contact were explored by asking the respondents: "On average, how many days per week do you have *face-to-face contact* with others (family, friends)?"; "On average, how many days per week do you have *online/virtual via text message or video* with others (family, friends)?"; and "On average, how often do you have contact with *groups or organisations* (hobby group, social club, church) per week?". The respondents were asked to indicate the number of close friends/relatives by answering the question, "How many close friends and/or close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?" Physical health and mental health were self-reported by completing the following two questions: "How would you describe your physical health?" and "How would you describe your mental health?" (1 = Very poor – 6 = Excellent).

## Data Analysis

The data was analysed using IBM SPSS, Version 27, by the second author. Descriptive statistics were computed for the sociodemographic variables, loneliness and social support variables, types of social contact, and physical and mental health. Independent samples *t*-tests were run to explore, among others, any statistically significant differences in the level of loneliness and social support between community-dwelling older persons and older persons residing in residential care facilities. Significance was set at the 5% level (Gravetter et al. 2021).

## Ethical Considerations

The respondents provided written informed consent before participating in the study. The informed consent included the details of social workers who were available for counselling, should the survey result in any emotional harm to any respondent. No respondent required counselling. Participation was voluntary. The identity and privacy of the respondents were protected. Lockdown measures were followed to prevent any physical harm. All field workers were properly trained and signed a confidentiality agreement (Strydom and Roestenburg 2021). Ethical approval for data collection among both groups was obtained from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (Ref nos: HUM003/0321 and HUM002/0222). Additionally, the management of the participating welfare organisation and service centre provided written permission for the study.

## Results

### Profiles of the Respondents

After removing 21 cases due to missing items, 118 community-dwelling older persons were included in the data analysis. In terms of socio-demographics, the mean age of the respondents was 72.6 years (SD = 7.1) with a range of 60–90 years; 72% identified as female; 92.3% identified their home language as Afrikaans; 85.3% resided in urban or semi-urban areas; and 50% reported living in Gauteng. Most of the respondents held a qualification of a Bachelor's degree/Honours degree/Professional degree (27.1%); followed by those with a Grade 12/Matric certificate (21.2%), or a National Diploma (21.2%). Most of the respondents (79.5%) were retired/pensioners. The largest percentage of the respondents (45.3%) were married/partnered; 46.6% were living with a spouse/partner; followed by 40.5% who were living alone. The mean number of children for the respondents was 2.8 (SD = 1.4) with a range of 0–11 children. Nearly 98% of the respondents reported Christianity as their religion or spiritual belief.

A total of 99 older persons residing in private residential care facilities were included in the analysis. The mean age of the respondents was 73.7 (SD = 7.3; range 54–88), with 80.8% identifying as female. The majority of the respondents (80.8%) indicated their home language as Afrikaans; followed by English (13.1%), and Setswana (4.0%). All the respondents resided in an urban area in Gauteng. Over 40% of the respondents held a qualification of some high school training, followed by 35% who held a qualification of Grade 12/Matric. The majority (93.9%) were retired/pensioners. The largest percentage of the respondents were widowed (48.5%) or divorced (23.2%) and resided in a room within a residential facility (65.7%). The mean number of children for the respondents was 2.1 (SD = 1.6; range 0–7). Nearly 88% of the respondents reported Christianity as their religion or spiritual belief.

### Health and Social Contact during Covid-19

The community-dwelling older persons reported their physical and mental health to be between good and very good and had, on average, 5.3 days of face-to-face contact a week; 5.9 days of online/virtual contact a week; and 2.5 days of contact via groups/organisations a week. The respondents reported a mean of 7.1 close friends or relatives with a range of 0–50.

Similarly, older persons in residential care reported their physical health to be between fair and good, and their mental health was reported to be between good and very good. The respondents had, on average, 1.7 days of face-to-face contact a week; 4.4 days of online/virtual contact a week; and 1.3 days of contact via groups/organisations a week. The respondents reported a mean of 5.6 close friends or relatives with a range of 0–40.

Table 1 reports the respondents' health and social contact during Covid-19. The respondents residing in residential care reported worse physical health and mental health; less face-to-face, online/virtual, and group/organisational contact; and fewer close friends or relatives (number of supports) when compared to community-dwelling respondents. Independent samples *t*-tests indicated that four of the observed differences between community-dwelling older persons and older persons residing in residential care facilities were statistically significant ($p < .01 – p < .001$). Older persons residing in residential care facilities were found to report worse physical health, and less face-to-face, online/virtual, and group/organisational contact during Covid-19 when compared to community-dwelling older persons. The effect sizes for these changes in social supports were small to medium ($d$ = .4 – .7) according to Cohen's (1988) guidelines (Gravetter et al. 2021).

**Table 1:** Health and social contact: Community-dwelling versus residential care

| **Variable** | **Community-dwelling** | **Residential care** | | | |
|---|---|---|---|---|---|
| | ***M (SD)*** | ***M (SD)*** | ***t*** | ***p*** | ***df*** |
| Physical health | 4.4 (.9) | 3.9 (1.0) | 3.02 | < .01 | 214 |
| Mental health | 4.8 (.9) | 4.6 (1.1) | 1.39 | .17 | 215 |
| Face-to-face | 5.3 (1.9) | 1.7 (2.3) | 12.51 | < .001 | 206 |
| Online/Virtual | 5.9 (1.5) | 4.4 (2.7) | 5.32 | < .001 | 213 |
| Groups/ Organisations | 2.5 (1.9) | 1.3 (1.9) | 4.67 | < .001 | 213 |
| Number of supports | 7.1 (7.3) | 5.6 (6.1) | 1.56 | .12 | 209 |

### Social, Emotional and Overall Loneliness: Community-Dwelling versus Residential Care

Table 2 outlines social, emotional, and overall loneliness. Although older persons residing in residential care facilities reported lower levels of social, emotional, and overall loneliness than community-dwelling older persons, the observed differences were not statistically significant.

**Table 2:** Loneliness: Community-dwelling versus residential care

| **Variable** | **Community-dwelling** | **Residential care** | | | | |
|---|---|---|---|---|---|---|
| | ***M (SD)*** | ***M (SD)*** | **Theoretical range** | ***t*** | ***p*** | ***df*** |
| Emotional loneliness | 20.2 (7.3) | 19.9 (8.3) | 6–36 | .20 | .84 | 196 |
| Social loneliness | 12.3 (5.2) | 12.2 (5.7) | 5–30 | -.09 | .93 | 215 |
| Overall loneliness | 32.3 (10.8) | 32.1 (11.3) | 11–66 | .09 | .92 | 215 |

**Social Supports: Community-Dwelling versus Residential Care**

Table 3 reports the MOS social support scale data. Emotional/informational support, affectionate support, positive social interaction, and overall social support were less for older persons residing in residential care facilities versus community-dwelling older persons, yet tangible supports were higher for older persons residing in residential care facilities versus community-dwelling older persons. The least amount of support for both groups was positive social interaction. The rankings of the different types of social support varied between the two groups with affectionate support being the highest rating for community-dwelling older persons while affectionate support was rated second least for older persons residing in residential care facilities. Independent samples *t*-tests indicated two of the observed differences between community-dwelling older persons and older persons residing in residential care facilities were statistically significant ($p < .01 – p = .04$). The effect sizes for these changes in social supports were small ($d = .3 – .4$) according to Cohen's (1988) guidelines (Gravetter et al. 2021).

**Table 3:** Social supports: Community-dwelling versus residential care

| **Variable** | **Community -dwelling** | **Residential care** | | | | |
|---|---|---|---|---|---|---|
| | ***M (SD)*** | ***M (SD)*** | **Theoretical range** | ***t*** | ***p*** | ***df*** |
| Emotional/ Informational support | 69.4 (26.6) | 67.6 (29.2) | 0–100 | 4.7 | .64 | 213 |
| Tangible support | 71.5 (28.9) | 74.7 (26.2) | 0–100 | - .84 | .40 | 212 |
| Affectionate support | 73.2 (27.9) | 61.8 (32.2) | 0–100 | 2.7 | < .01 | 193 |
| Positive social interaction | 67.8 (29.3) | 58.9 (34.7) | 0–100 | 1.9 | .04 | 190 |
| Overall social support | 69.8 (25.6) | 66.5 (26.4) | 0–100 | .92 | .36 | 213 |

## Limitations of the Study

The study should be considered within the context of some limitations. Firstly, the data collection was limited to five of the nine provinces. Budget constraints further limited the sample of older persons in residential care to one province, namely, Gauteng. Therefore, the results cannot be generalised. Secondly, lockdown measures did not allow for simultaneous data collection; hence, the data was collected over two consecutive years. Thirdly, the data collection was limited to two official languages of the country. As an aftermath of colonialisation and apartheid, Afrikaans- or English-speaking older persons may experience better physical and mental health due to having access to quality education; being in jobs with access to pension schemes and private health care through medical schemes which increase their life expectancy; and living in nuclear families (Stats SA 2023b). In contrast, older persons who were discriminated against under apartheid often face numerous challenges that impact negatively on their well-being, such as poor health care; relying on social security; living in poverty; lacking affordable housing; experiencing food insecurity; and living in extended households, thereby making them vulnerable to elder abuse (Patel 2015). The study's results and discussion thereof should be interpreted along these realities. Fourthly, the data could not be collected during the peak of the Covid-19 pandemic in 2020. Thus, the authors had to collect data retrospectively, which could mean that older persons either could not fully recall or underreported the intensity of their experiences. Nonetheless, the study was the first of its kind originating from the Global South, specifically a country on the African continent.

## Discussion

Both community-dwelling older persons and those in residential care were in their early seventies during the time of data collection, which exceeds the life expectancy of South Africans and may signal some of the privileges experienced by the language groups presented in the study (Stats SA 2023b). Most of the respondents identified as female which corresponded with national census data (Stats SA 2023b). Community-dwelling older persons had higher levels of education than their counterparts in residential care. However, their educational level was still higher than most older persons (Stats SA 2023b) and could be considered a strength associated with the racial groups included in the study. As expected, most of the respondents were retired/pensioners, with many being part of the 70.3% of older persons in South Africa who are recipients of an old age grant (Stats SA 2023a). This is a valuable resource in their lives.

Almost half of the community-dwelling older persons lived with a spouse/partner which is considered a buffer against emotional loneliness (Van Tilburg 2022). Older persons in residential care mostly reported being widowed or divorced, and living alone, which could increase their experience of loneliness, especially if they do not share a room in the facility (Savci et al. 2021). With on average more than two children alive, this could be a strength and support to older persons during a pandemic. Most of the respondents identified as Christian and this could be a further source of strength to mitigate emotional loneliness and enhance emotional support during a pandemic (Emerson et al. 2022; Kenkmann and Burkard 2022).

Older persons residing in residential care facilities are expected to be frail. This could explain why they reported their physical health as statistically significantly poorer than their counterparts living in communities. Furthermore, the results indicated the effect of the lockdown measures on the social contact of older persons in residential care. The latter reported significantly less face-to-face and online/virtual contact, and participation in groups/organisations. The findings were not unique and corresponded with similar trends reported by Gao, Mosazadeh and Nazari (2023) in Iran and Savci et al. (2021) in Turkey. As such, it would seem that community-dwelling older persons could still benefit, albeit to a limited degree, from the strengths associated with social interaction with others and as such continue to experience some social support (Vlachantoni et al. 2022).

The research questions centred on the levels of loneliness and social support among community-dwelling older persons and older persons in residential care during Covid-19, and whether statistically significant differences were prevalent. The results showed that both groups experienced moderate levels of overall, social and emotional loneliness. More specifically, community-dwelling older persons experienced marginally higher levels in all domains of loneliness. The results for community-dwelling older persons indicated that they mostly experienced higher levels of overall and emotional loneliness than their counterparts in the US (Teater, Chonody and Hannan 2021). Similar to findings among community-dwelling Dutch older persons, the Covid-19 pandemic had a greater effect on their emotional loneliness than social loneliness (Van Tilburg et al. 2021).

When considering the case of older persons in residential care, the results indicated that the South African respondents experienced higher levels of overall loneliness than older persons in Iran, Switzerland and Turkey (Gao, Mosazadeh and Nazari 2023; Huber and Seifert 2022; Savci et al. 2021). The salient results reported in the present study would seem to confirm the mitigating factors reported in the literature, namely, that older persons experience less loneliness when they have higher levels of education; more regular communication through phone and video calls; greater social networks available; and better physical health (Onal et al. 2022; Savci et al. 2021; Van Tilburg 2022). The aforementioned could be considered abilities and strengths which, considered from the strengths perspective, could be identified and activated to alleviate loneliness among older persons during a pandemic. With a larger sample in future studies, these conclusions could be confirmed through ANOVA and regression analyses.

Taking into account the availability of peers in residential facilities, medical and psychosocial staff, and hospitality services, the authors would have expected higher levels of social support among older persons in residential care. Interestingly, the results showed a different picture. Except for tangible support, all domains of social support were found to be higher among community-dwelling older persons. Similar to the present study's results, Burnette, Duci and Dhembo (2017) found that older persons in Albania who reported poorer physical and mental health, often experienced less social support.

Affectionate support scored significantly lower among older persons in residential care. One explanation could be that the sample was mostly widowed or divorced, thus without someone to share love and experience affection from. In Canada, similar variables were found to negatively impact older persons' affectionate support (Menec et al. 2020). Considered from the strengths perspective, it would seem that being married/partnered;

living with a spouse/partner; and having more close friends are important sources to increase the experience of affectionate support.

Positive social interaction was found to be significantly lower among older persons in residential care. One explanation could be that community-dwelling older persons reported having more face-to-face and online/virtual contact; spending more days in group/organisation activities; and having more close friends. In the UK, Vlachantoni et al. (2022) identified the same variables having a negative impact on older persons' social interaction. As indicated earlier, the authors did not identify another study implementing the MOS Social Support Survey, therefore limiting direct comparisons. Nonetheless, the pertinent results reported in the study in terms of social support, and the buffers to protect older persons against decreased social support, are confirmed in the literature, for example; living with a partner; maintaining social relationships; having regular check-ins from friends and professionals; connecting to the outside world through information and communication technologies (ICTs); and experiencing good physical health (Menec et al. 2020; Smith, Steinman and Casey 2020; Van Tilburg 2022).

## Recommendations: Implications for Gerontological Social Work Services

When applying the strengths perspective, the starting point is people's abilities, strengths and resources (Kondrat 2020). Community-dwelling older persons are often married/partnered; do not live alone; have children; and report being religious. Older persons in residential care have children and access to staff in the facility. These could be explored during gerontological social work services and capitalised on to buffer against loneliness and decreased social support. Even during physical distancing, distanced door visits, phone and video calls, online meditation and church services could be introduced (Conroy et al. 2020; Gorenko et al. 2020; Vlachantoni et al. 2022).

Seen holistically, community-dwelling older persons had more social contact during the pandemic than those in residential care. Social workers in residential care should consider establishing support groups (with physical distancing and wearing face masks) to attend to older persons' need for social interaction. In the absence of in-person social interaction, social workers should explore options for solutions with older persons, such as playing online games; streaming music; and watching uplifting movies, to improve their emotional loneliness and offer emotional support (Conroy et al. 2020; Sepúlveda-Loyola et al. 2020). The use and acceptance of information and communication technologies (ICTs) among older persons should be assessed and a community education project established to train older persons to use ICTs to a level that is meaningful to them in order to maintain social contact. In this regard, intergenerational contact could be ideal where younger generations teach older persons to use ICTs and in return benefit from older persons' wisdom. Volunteers could also be asked to give befriending phone calls to older persons (Jarvis, Sartorius and Chipps 2020; Sepúlveda-

Loyola et al. 2020). The latter implies a low-technology alternative for resource-constrained settings, such as South Africa.

However, the challenges and effects of the pandemic on the mental health of older persons should not be ignored. Hence, the higher levels of loneliness among community-dwelling older persons should be adequately addressed. In their systemic review of interventions to reduce loneliness, Williams et al. (2021) identified interaction with animals, online games, gardening, virtual calls and telephonic befriending as the most effective among older persons. However, a bottom-up approach must inform social workers to explore with older persons which of the mentioned interventions may be meaningful to them to maintain well-being during a pandemic. In residential care facilities, social workers could embark on interdisciplinary group work, for example, partnering with an occupational therapist, to mitigate the loneliness of older persons, such as establishing creative activities (e.g. board games, colour in) for older persons, while maintaining physical distancing; or reminiscing in groups where older persons share events, people and places to address their emotional support needs. Religious practices could be maintained where clergy preach over an intercom system while everyone remains in their rooms could also address social loneliness (cf. Bethell et al. 2021). The aforementioned represent low-technology alternatives for resource-constrained settings.

Older persons in residential care reported lower levels of social support, especially affectionate support and positive social interaction. Should older persons not have the means and skills to use ICTs (e.g. online chats, video calls), low-technology alternatives should be explored, especially amidst the perpetuating load shedding (i.e. scheduled electricity interruptions) in South Africa. For example, arranging with organisations to bring animals to the facility to allow older persons to interact with animals could address their affectionate support needs. Positive social interaction could be addressed through befriending phone calls. Community work projects could also be launched to donate books, magazines, board games and puzzles and distribute them to older persons. These activities have been found to mitigate social loneliness and address a lack of positive social interaction (Sepúlveda-Loyola et al. 2020; Williams et al. 2021).

## Concluding Remarks

Before the next pandemic hits South Africa, future research should focus on a more representative sample to ensure that gerontological social work services are designed and policies changed, where necessary, to attend to all South African older persons' loneliness and social support needs. Older persons are a vulnerable group in society and deserve locally relevant and evidence-informed services to maintain their quality of life.

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