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The relationship between loneliness, communication apprehension, and selected demographic variables

Nancy Maloney-Mercado
San Jose State University

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Maloney-Mercado, Nancy, M.A.

San Jose State University, 1989

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The Relationship Between Loneliness,
Communication Apprehension, and
Selected Demographic Variables

A Thesis

Presented to

The Faculty of the Department of
Communication Studies
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

By

Nancy Maloney-Mercado

December, 1989

APPROVED FOR THE DEPARTMENT OF COMMUNICATION STUDIES

Dr. Cal Hylton

Dr. Jack Ray

Dr. Wen-Shu Lee

APPROVED FOR THE UNIVERSITY

M. Lou Lewandowski

ABSTRACT

The Relationship Between Loneliness, Communication Apprehension, and Selected Demographic Variables

by Nancy Maloney-Mercado

This thesis explores the relationship and differences between and among loneliness, age, communication apprehension, living situations, health, gender, number of social contacts, and confidant availability.

The results indicate that the lack of numerous social contacts or the aging process do not contribute to loneliness. Respondents reporting confidant availability also report a larger number of social contacts ($F=5.75$, $p<.002$). It was clear that poor health was more likely to be a problem among respondents lacking a confidant ($F=11.20$, $p<.000$) and among the aged ($F=5.34$, $p<.02$). Even though communication apprehension did not correlate with loneliness, there was a nonsignificant trend toward older women experiencing more communication apprehension than their counterparts ($F=3.36$, $p<.06$). These findings suggest that the quality of a relationship is more important to an individual's health than the quantity of relationships. A relationship with a confidant, invariably leads to increased social contact; however, the reverse is not true.

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TABLE OF CONTENTS

		PAGE
	Acknowledgments.....	iv
	List of Tables	vii
CHAPTER		
1	Introduction.....	1
	Summary of Introduction and Hypothesis.....	10
2	Survey of Related Literature.....	13
	Activity Theory.....	13
	Content of Loneliness.....	14
	Loneliness and Old Age.....	17
	Content of CA.....	18
	CA and the Elderly.....	20
	Summary of Related Literature & Research Questions.....	22
3	Method.....	24
4	Results.....	28
5	Discussion.....	33
	REFERENCES.....	39
	APPENDICES.....	45
	Appendix A: Tables.....	46
	Appendix B: Communication Apprehension Questionnaire.....	57
	Appendix C: Loneliness Questionnaire.....	59
	Appendix D: Demographics Questionnaire...	61

LIST OF TABLES

TABLE		PAGE
1	Analysis of Variance, Confidant Availability by Levels of Age.....	47
2	Analysis of Variance, Confidant Availability by Levels of Sex.....	48
3	Analysis of Variance, Social Contact by Levels of Confidant Availability.....	49
4	Analysis of Variance, Health by Levels of Confidant Availability.....	50
5	Analysis of Variance, Health by Levels of Age.....	51
6	Analysis of Variance, Loneliness by Gender.....	52
7	Two-Way Anova (Sex by Age) for Communication Apprehension.....	53
8	Two-Way Anova (Sex by Confidant Availability for Health	54
9	Two-Way Anova (Age by Confidant Availability) for Health	55
10	Bivariate Correlations for all Variables in the Study.....	56

CHAPTER 1

INTRODUCTION

Research indicates that the elderly often experience increased loneliness and anxiety. Lord Byron's poem, "Childe Harold," (cited in Bartlett, 1980), recaptures these sentiments about aging, apprehension, and loneliness when he writes:

What is the worst of woes that wait on age?

What stamps the wrinkle deeper on the brow?

To view each loved one blotted from life's page,

And be alone on earth, as I am now. (p. 457)

Little wonder that with such a negative image of age painted in these somber colors, Western culture has built up a fear of aging (Bortz, 1963) which is exacerbated by the fear of rejection, embarrassment, dependency, becoming ill, inactivity, forgetfulness, unimportance, and loneliness. These fears are often expressed in stereotyped labels and images which may often cause our seniors to withdraw or avoid communication with younger persons.

However, a paucity of research exists evaluating the impact of communication apprehension (CA) and loneliness in the lives of older adults (Downs, Javidi, Nussbaum, & Robinson, 1987); it appears that the Downs' study is the only research identifying an existing relationship between these three variables. The study found high levels of loneliness for respondents ages 50-59 ($n=14$, $M=30.16$) and for those over 80 ($n=6$, $M=38.41$). However, the sample size was relatively small (60 respondents) and did not include younger adults so that a true age comparison could be made. Results of the correlational analysis, in the Downs' study, suggest a moderate and positive relationship between perceptions of loneliness and communication apprehension scores ($r=.42$; $.59$ corrected for attenuation due to measurement error).

The Downs' study recommends additional studies investigating living situations, health levels, and gender differences among the elderly.

The present study proposes to explore the relationship between age, loneliness, CA, living situations, health, gender, amount of social contacts, and confidant availability. A review of research findings pertinent to these variables provides some indication as to why they have not been extensively explored, at least, among the elderly.

Who are America's aging? Bohmbach (1986) reports that in 1935, the average life-span was just 64; now the life-span has stretched out a full decade, to 74.9 years. Dobson (1987) states that people over 65 comprise 12 percent of the population and by the year 2030 this proportion will rise to 20 percent. In the United States the population of older people has grown from 18,000,000 in 1965 to 28,000,000 in 1987. Oyer and Oyer (1976) reports that "the United States is becoming a nation of older people" (p. 5). Furthermore Oyer and Oyer (1976) relates that "the interests and concerns for older people have become truly national in scope" (p. 4).

Population changes are forcing politicians, social scientists, communication scholars, gerontologists, and gerontology counselors to address the concerns of the elderly.

Politicians recognize the importance of the elderly population. The social visibility of older persons has increased their political visibility. The older voter constitutes approximately 19% of the electorate (Oyer & Oyer, 1976). A greater proportion of those people over 55 vote in presidential elections than do adults in any other age group, with the exception of the 45-55 group (Geist, 1968).

Social scientists have focused primarily on the elderly in such areas as life satisfaction (Gubrium, 1976), adjustment to retirement (Cowgill & Holmes, 1972), isolation (Cumming & Henry, 1961), and diminishing capacities.

Researchers in communication, however, are concerned with aging based on communication patterns (e.g. Nussbaum, 1983, Ray, Hylton, & Gadke, 1984).

Gerontology researchers have been increasingly awakened to examine loneliness among the elderly (Mullins, Johnson & Andersson, 1987), and they report that the concerns of the elderly have become international in scope.

Gerontology counselors in Santa Clara County are reporting an increased number of agoraphobic (fear of making contact, fear of going outside) individuals. In addition, gerontologists are visiting more elderly who are living in relatives' homes as well as discovering a growth in the number of elderly who are withdrawing. The counselors attribute the withdrawal tendencies of our older population to a fear of rejection.

Director of Community Affairs for the Council of Aging, Santa Clara County, Paul Isaacs states, "the national nutrition programs for seniors (60 and over) were established for the prime purpose of providing socialization. However, many Americans are under the impression that the programs are provided to feed the hungry. The elderly partake in the nutrition programs, not because the food is nutritionally sound, but because it offers them an opportunity, a reason to get up, get out, meet other people, and talk with other people" (personal communication, April 6, 1988).

The Older Americans' Act of 1965 further states that "besides promoting better health among the older segment of our population through improved nutrition, such a program would reduce the isolation of old age, offering older Americans an opportunity to live their remaining years in dignity" (p. 689).

Researchers of loneliness, Mullins, Johnson and Andersson (1987) state, "...even though loneliness is an important consideration of old age, there is no clear understanding of its development among the elderly" (p. 226).

Does aging need to imply loneliness for our elderly population? Although loneliness occurs at every age, a common stereotype is that it is associated with being old. Is this relationship between loneliness and old age a myth or a reality? Creecy, Berg, and Wright (1985) found that "loneliness is a serious problem for elderly adults that affects from 12 to 40 percent of the total population age 65 years or older" (p. 487).

Loneliness researchers recognize that loneliness is an important consideration for all ages. One national survey, (Bradburn, 1969) reports that 26% of Americans felt very lonely or remote from other people during the weeks questioned. Loneliness was linked to a variety of other serious individual health and social problems including alcoholism (Nerviano & Gross, 1976), depression (Russell, Peplau, & Cutrona, 1980), anxiety and tension (Loucks, 1980),

physical illness (Lynch, 1976), suicide (Wenz, 1977), boredom, self-deprecation, and interpersonal hostility (e.g. Jones, Freemon, & Goswick, 1981; Russell, Peplau, & Ferguson, 1978).

"The role of gender differences in the experience and effects of loneliness remains unclear" (Jones et al., 1981, p. 46). Clark and Anderson (1980) found:

Women, on the average, have more social roles and a larger number of friends than men do; yet, women are considerably more likely than men to complain of loneliness and a paucity of social contacts. (p. 267)

"In relation to the loneliness construct, research suggests that living situation may impact the level of perceived loneliness experienced by an individual" (Downs et al., 1987, p. 29). The living situations described within the present study are: alone, with relative, with friend, or with spouse.

-The study of loneliness is relatively recent with its beginnings, traced to the 1970's (Paloutzian & Janigian, 1987). Loneliness studies can be divided into three stages of development. In the first stage, social scientists were concerned with mapping out the parameters of loneliness. It appears that age and communication dysfunctions were not considerations.

The second stage of loneliness studies, according to Paloutzian and Janigian (1987),

includes refinement in measurement techniques,

postulating conceptual models for the phenomenon, and hypothesis testing studies. Loneliness research has been in this second phase for about a decade. This is evident, for example, by the more than 25 empirical studies published in the Journal of Personality and Social Psychology and Social Psychology Bulletin alone since 1980 (pp. 31-32).

The UCLA Loneliness Scale was developed by Russell in 1978 and revised in 1980. The revised version of the scale will be one of the measurements utilized in this study.

The third phase involves advances in theory to assimilate and accommodate to the empirical findings (Paloutzian & Janigian, 1987, p. 32).

Somewhere during these three stages of loneliness development, numerous definitions for loneliness were postulated. Four loneliness definitions pertinent to this study are:

1) Sermat (1978) states that loneliness is the lack of an opportunity to talk about personally important, private matters with someone else (p. 332). 2) Peplau and Perlman's definition (cited in Bell & Daly, 1985) suggests that loneliness exists to the extent that a person's network of social relationships is smaller or less satisfying than the person desires (p. 122). 3) Wintrob (1987) reports that loneliness is a sense that there is nobody with whom to share the vulnerable aspects of life (p. 80). 4) Creecy, Berg, and

Wright (1985) define loneliness as a psychological condition resulting from losses in the individual's support system, a decreased participation in social activities, and a reduced sense of social fulfillment (p. 228).

As the result of these loneliness definitions, two other variables are included in this present study: 1) confidant availability and 2) number of social contacts, since they appear to be implicitly or explicitly included in the loneliness definitions.

Somewhere in the third stage of loneliness development, researchers such as Bell and Daly (1985) suggested that a lonely person is a person who is apt to experience problems in communication such as: "apprehension and anxiousness about communication and social situations, difficulty being responsive to others, having problems with self-assertion, and tending to be nondisclosive. The lonely person evaluates their ability as a communicator negatively" (p. 121). Researchers further state that a person lacking in interpersonal skills is less able to initiate, establish, and maintain satisfying relationships. Then "any communication dysfunction appearing generally in society may be greatly amplified for aging persons" (Oyer & Oyer, 1976, p. 219).

One communication dysfunction, communication apprehension (CA), has over 200 documented studies. Researchers and educators in speech communication have focused on the antecedents and correlates of CA (Downs, et al., 1987).

McCroskey (1982) defines communication apprehension as "an individual level of fear or anxiety associated with either real or anticipated communication with another person or persons" (p. 221).

Downs, et al., 1987 writes:

Communication apprehension has been associated with several other communicative variables such as limited involvement in communicative interaction (Downs, 1986), self-disclosure patterns (Miller, Berg, & Archer, 1983), argumentativeness (Infante & Rancer, 1982), assertiveness (Bell & Daly, 1985), social responsiveness, attentiveness, and perceptiveness (Cegala, Savage, Brunner, & Conrad, 1982); and personality-type variables such as loneliness (Bell & Daly, 1985), avoidance of risk taking (Rocklin & Revelle, 1981), dependency and self-criticism (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982), and social isolation (Mortensen, Arntson, & Lustig, 1977). (p. 10)

The effects of CA are experienced by individuals both internally and externally (McCroskey, 1982). Downs et al. (1987) states, "When experienced internally, feelings of physical discomfort are evident. Externally experienced CA may manifest itself in avoidant, disruptive, and withdrawing behaviors" (pp. 9-10).

It certainly appears that the traits and antecedents associated with CA correlate with loneliness. Zakahi and

Duran (1982) state that communicative apprehensives avoid situations that demand communication, interact less with peers, and live in remote areas. "The research would seem to indicate, that as a group, they are more likely to be lonely...The communicative apprehensive's avoidance of situations which involve communication provides an additional link to loneliness" (p. 205).

Summary of Introduction and Hypothesis

In order to determine if the elderly are experiencing CA and loneliness, more studies addressing these variables are required. If the elderly are experiencing excessive fear, anxiety, and loneliness, how can they communicate to the larger community about the aging process and the problems concerning aging persons?

Both the elderly and the members of the larger community have a duty to exchange information. Muth (1976) writes:

Aging persons will always remain the most reliable source of information about aging and the problems facing aging persons (Johnson, 1972). Aging persons must function as citizens; therefore, they need to communicate with the larger community. If the aging fail to advise the larger community of their problems, there is little hope for resolution (Markson, 1971). If the aging are determined to preserve and assert legal and political rights, they must communicate effectively with society (Cain, 1974b). (pp. 217-218)

In addition, interaction between generations reduces negative stereotypes that one generation has about the other. Also, more contact between generations increases understanding and appreciation of the other (Wood, 1982).

Oyer and Oyer (1976) further state that "in pastoral societies, the aging are respected not merely because of their advanced state of years, but because of the wisdom they impart to the larger community. They communicate information concerning their status and well-being, and they offer seasoned, deliberate judgment on matters of general concern. The respect for their age derives from the wisdom they articulate" (p. 218). If the elderly are experiencing communication dysfunctions, they will not be articulating their wisdom to American society.

Then, too, if the generation gap continues to exist in our society, the elderly will be inclined to withdraw, avoiding the exchange of information. This avoidance or withdrawal from communication could affect the individual's ability to initiate and/or maintain intimate relationships.

Also, with the possible intense feeling of fear operant in the elderly, is it not likely that a large portion of our older population is experiencing communication apprehension and loneliness? The available research studies in communication and gerontology, to date, do not provide a clear answer.

Therefore this study explores the following general hypothesis: Age, communication apprehension, sex, amount of social contacts, confidant availability, health, and living situation will account for a significant amount of variance in loneliness.

CHAPTER 2

Survey of Related Literature

Literature which might contribute to this study should be found in the categories of: Activity Theory, Loneliness, Loneliness in Old Age, Communication Apprehension, and Communication in the Elderly, which might provide additional enlightenment into the possible relationship of loneliness and the seven variables or reveal some differences that might occur among the variables mentioned in this study.

Activity Theory

According to Activity Theory (Atchley, 1977), the maintaining of fairly constant amounts of activity or social participation among the elderly depends upon the amount of activity that the individual utilized in younger years and upon socioeconomic forces rather than upon age itself. Indeed, the association between activity level and morale may grow stronger rather than weaker with advancing age (Tobin & Neugarten, 1961; Graney, 1975). Activity involvement has consistently been shown to be important to longevity (Palmore & Jeffers, 1969; Bartko, Patterson, & Butler, 1971). Thus, "maintaining substantial levels of physical, mental, and social activity is considered necessary for successful adjustment to aging" (Botwinick, 1978, p. 81).

Activity (particularly communicative activity) is related to loneliness and happiness. Loneliness among elderly adults (70 and above) was reported as a decrease in or a lack of activity (Dean, 1962; Atchley, 1977). Happiness among the aged correlates positively with social activity in many studies (e.g., Palmore & Jeffers, 1969; Graney, 1975). At least one author claims that the activity most important to successful aging is communication. "Of the social activities highly associated with happiness, most involved face-to-face interaction or the potential for this" (Graney, 1975, p. 705).

Botwinick (1978) further states that for the most part, well-being and happiness go with activity, not disengagement.

Content of Loneliness

Previous attempts to find a correlation between loneliness and age have been unsuccessful. Also, an attempt to confirm a relationship between CA and loneliness was unsuccessful in the Zakahi and Duran (1982) study. However, Zakahi and Duran (1985) write:

Earlier research (Zakahi & Duran, 1982) suggested the relationship of loneliness, communicative competence, and communication apprehension was such that communication apprehension did not contribute to the problem of loneliness. If not for the commonality analysis, this

research would come to much the same conclusion. Dyadic apprehension contributed only 1 percent of the variance in the initial multiple regression. Its value for dealing with loneliness was apparently quite small. When the multiple regression was decomposed into unique and common variance, it was found that dyadic apprehension helped to account for nearly half of the total variance in the model. This analysis could have an impact on the treatment of loneliness. It is important that when dealing with loneliness from a communication perspective communication apprehension be considered. Attempting to teach a lonely person social skills (e.g., social experience and social confirmation) without concomitantly treating apprehension would prove fruitless. (p. 58)

Also, the authors report, in their 1985 study, that social experience and social confirmation (two dimensions from the Communication Adaptability Scale, Duran, 1983) and dyadic apprehension (one dimension from the PRCA) contribute to loneliness.

Additional research states that loneliness has been positively correlated with shyness, low self-esteem, depression, and anxiousness (Jones, Freemon, & Goswick, 1981; Russell et al., 1978; Loucks, 1980; Jones, Hobbs, & Hockenbury, 1982).

Research (Jones, Freemon, & Goswick 1981; Jones, Hobbs & Hockenbury, 1982; Horowitz & French, 1979; Gerson & Perlman, 1979; Peplau & Perlman, 1982) shows that the lonely display some of the following: 1) less interactions with intimate others; 2) generating fewer and less effective solutions to hypothetical interpersonal problems; 3) less disclosiveness; 4) sharing fewer opinions; 5) giving more extreme responses; 6) talking more about themselves; 7) providing fewer social rewards to their conversational partners; 8) missing others' verbal cues of friendship; and 9) encoding inaccurately expressive nonverbal communication. Overall, research suggests that lonely people may communicate differently and less skillfully than non-lonely people and that the loneliness some individuals experience may be a consequence of their inability to interact effectively with others. "Therefore, research has indicated that the lonely person lacks emphatic abilities, social experiences, and general communication skills" (Zakahi & Duran, 1982, p. 205).

Jones, Hobbs, and Hockenbury (1982) write:

Lonely adolescents and college students report social skill inadequacies including passivity (Brennan, in press), lack of assertiveness, greater shyness and self-consciousness (Jones et al. 1981), and problems of inhibited sociability (e.g., difficulty in making friends naturally and with ease (Horowitz & French, 1979). (p. 682)

Results of the Jones et al. (1982) research indicates a causal relationship between social skill deficit and feelings of loneliness. In addition, increased "partner attention" during a structured interpersonal interaction resulted in changes in reported feelings of loneliness. These results also support the view that quality of interaction may be an integral component in the study of loneliness.

Loneliness & Old Age

Creedy, Berg, and Wright (1985) found the following: There is considerable evidence relating to the social, physical, and emotional effects of loneliness among elderly adults. Within this population, loneliness has been associated with the incidence of endogenous depression and suicide (Breed, 1967); Payne, 1975) as well as with a number of psychosomatic disorders, including peptic ulcers, asthma, and other respiratory conditions (Bradley, 1967; Hall & Henderson, 1966). Loneliness has also been identified as a precipitating factor in the initial diagnosis of diabetes mellitus, coronary disturbances, arteriosclerosis, and other chronic disabilities (Henry et al., 1971; Hinkel & Wolf, 1952; Perlman et al., 1971). (pp. 487-488)

Loneliness among the elderly may be the product of cumulative losses. Some of the cumulative losses that, in varying degrees, characterize the condition of elderly persons are, for example, loss of a spouse, loss of real

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feelings of inferiority, to be fearful about risk taking, and to worry excessively (McCroskey, 1977).

Both the lonely and the communicative apprehensive individual would tend to avoid, disrupt, distort or withdraw from communication (Downs, et al., 1987). Researchers suggest that in most human communication transactions some risk is involved for a person who chooses to communicate with another person. The level of trust is directly correlated with the willingness of people to encode and transmit messages to another (Burgoon, Heston, & McCroskey, 1974).

Overall, there appears to be a general consensus that a relationship between trust and self-disclosure does exist (Cozby, 1973; Pearce & Sharp, 1973). There is a host of research that could be interpreted as supporting the notion that increased disclosive communication produces trust (e.g., Deutsch, 1968; Loomis, 1959; Ostermeier, 1967; Worth, Gary, & Kahn, 1969; Wheelless & Gortz, 1975). Therefore, since the elderly have less chance for social interaction, they would have less opportunity to establish trusting self-disclosive relationships with others.

Jourard (1971), one of the pioneer researchers in the area of self-disclosure, states that "a person will permit himself or herself to be known when he or she believes his or her audience is a person of good will. Self-disclosure follows an attitude of love and trust" (p. 5). Indeed, the process of self-disclosure does impose certain risks that an

individual must take such as: becoming defenseless and unguarded, receiving negative feedback, fear of exposure, or risking a "reverse halo effect" (the possibility that revealing one weakness about the self will lead the disclosed-to-person to generalize about other weaknesses the discloser might have). Thus, it would appear that the discloser should have positive perceptions of his or her target, including perceptions of trustworthiness, before he or she takes such risks (Wheelless & Grotz, 1975).

Communication Apprehension and The Elderly

With our American culture being a youth-oriented society, older ideas are more apt to be considered out-of-date or old fashioned. Would an older person be so inclined to share himself or herself with a target that has rejected his or her ideas over and over again? Often older people have complained, "No one will listen." No doubt the balance between talking and listening, which is at the heart of all communication, varies considerably during life.

Downs et al. (1987) report that "CA is positively correlated with feelings of loneliness in an older population" (p. 26); however, their study was limited to a small sample of older persons. Most other studies of apprehension and loneliness have been limited to samples of adolescents and college-aged students. No study was discovered in this literature search that actually compared communication apprehension and loneliness across major age groups.

During adolescence and college age, it becomes clearer to the adolescent or college-aged individual that some day soon he or she will have to physically and psychologically separate from his or her parents. In addition, the young person prepares intellectually to anticipate and experiment with a whole new range of life choices. Meanwhile, social expectations and physical growth push him or her toward greatly increased mastery and autonomy. The young person wonders whether he or she will be able to find a place in society where he or she will receive love and respect (Erikson, 1963). Adolescence and college age is a critical time for experiencing loneliness. Because of the cumulative changes, the threat that these changes are to the individual's identity, and the mourning for one's childhood, the adolescent and college-aged individual faces stress and fear. However, the stress and fear experienced by the young adult is not as intense as the stress and fear experienced by the elderly person.

The elderly are likely to perceive that they have less ability and opportunity to adapt and change to stress and fears (Loeb, 1973). Then, too, the elderly may not be able to develop and maintain new relationships and adapt to new environments because of negative attitudes which devalue them and assign them to "roleless" status (Sussman, 1983).

Summary of Related Literature & Research Questions

Additional research on Activity Theory, Loneliness, Loneliness in Old Age, Communication Apprehension, and Communication in the Elderly reveals that in old age, social engagement rather than disengagement is more closely related to psychological well-being. Without social contacts, respondents become demoralized and anxiety and pessimism characterize their attitude toward life (Clark & Anderson 1980, p. 276).

On the other hand, Clark and Anderson (1980) state that "healthier respondents show a deeper and wider commitment to the social milieu--they have more personal associations with others and show greater flexibility in making new friends in compensation for those lost" (p. 277). Social contacts are specifically named as sources of satisfaction for older members of our population.

These additional findings provide some basis for exploring the relationship among and between the following variables: loneliness, age, communication apprehension, confidant availability, number of social contacts, living situation, gender, and health. This study seeks to answer seven research questions based upon relationships suggested by the previous research noted:

1. Will there be a significant difference between older and younger people in terms of presence or absence of a confidant?

2. Will there be a significant difference between the sexes in terms of the presence or absence of a confidant?

3. Will there be a significant difference between respondents reporting the presence or absence of a confidant and the amount of reported social contact?

4. Will there be a significant difference between respondents reporting the presence or absence of a confidant and their stated health levels?

5. Will there be a significant difference between older and younger people in terms of their stated health level?

6. Will there be a significant difference between the sexes in terms of their reported loneliness?

7. Will there be a significant difference between the sex of participants and their reported social contact?

CHAPTER 3

METHOD

Design Method

In order to test the hypothesis and seven research questions, two separate analyses were employed. Multiple regression was employed to test the hypothesis. The seven predictor variables, in this analysis, were: age, CA, sex, health, confidant availability, number of social contacts, and living situation. The criterion variable was loneliness.

Analysis of variance was performed to test for differences between the variables contained in the research questions.

Respondents

Originally the sample was planned to include 100 older respondents and 100 younger respondents. However, two of the older respondents' questionnaires were incomplete. Therefore, the total sample consisted of 198 respondents. The older adult portion was obtained from senior citizen centers. The younger adult portion of the sample were students enrolled in Mission College classes.

Procedures

The researcher, or an assistant, arranged to collect the data during regularly scheduled meetings of the participants. The researcher explained that the purpose of the study was to explore communication practices and experiences, provided

instructions for responding to the scale items, and distributed the questionnaire. The questionnaire consisted of: 1) a scale to measure communication apprehension (See Appendix B), 2) a scale to measure loneliness (See Appendix C), 3) a measure of weekly contacts and 4) a measure for confidant availability, 5) demographic items for age, living situation, and gender, and 6) a health scale (See Appendix D). With the elderly portion of the sample, a few respondents required assistance with filling out or completing the questionnaire.

Measurement

Loneliness. The most frequently used unidimensional loneliness measure is the University of California, Los Angeles (UCLA) Loneliness Scale (Russell, Peplau & Ferguson, 1978). The original UCLA loneliness scale consisted of twenty statements relating to feelings of loneliness. Respondents were instructed to indicate whether they 'often,' 'sometimes,' 'rarely,' or 'never' felt as the statement indicated. Prior research has shown the measure to have a test/retest reliability of .73, and coefficient alpha of .96.

The revised loneliness scale, (Russell, Peplau, & Cutrona 1980) was the scale used in this study. The revised scale has a coefficient alpha of .94. Concurrent validity for the new measure was indicated by demonstrating that lonely people report experiencing emotions theoretically linked to

loneliness and do not report experiencing emotions unrelated to loneliness. Lonely individuals also reported more limited social activities and relationships. Discriminant validity for the revised loneliness scale was indicated by evidence that scores on the measure were not confounded by social desirability. Scores on the scale were also found to correlate more highly with other measures of loneliness than with the measures of mood and personality variables that were examined by Russell, Peplau and Cutrona (1980).

Communication Apprehension. Communication Apprehension was measured by employing the Personal Report of Communication Apprehension (PRCA) Version-24 and it contained five out of twenty-four statements recounting an individual's feelings about communication with other individuals (See Appendix B). The five statements measure an individual's present interpersonal communication. The instrument utilizes a 5-point, Likert-type scale extending from (1) strongly agree, to (5) strongly disagree. In an investigation reported by McCroskey, Simpson, and Richmond (1982), the PRCA Version-24 had an internal reliability coefficient of .96 and had reported consistently similar high reliability across many investigations.

Social Contacts. Social contacts were determined from self-reported information about the person's social contacts per week, (See Appendix D). A contact is a meeting with another person, which involves more than a casual exchange of

greetings. Peter Townsend (1973) reports the use of this measurement. The first step was to add together the average number of contacts a week with each relative, some of whom were seen together; the second was to add contacts with nonrelatives, mainly neighbors and friends but also, for example, nurses, home helps, and doctors; the third was to add on an arbitrarily chosen score for other social activities in one week. Thus, a weekly visit to a club, to the cinema, or to church was given a score of 2; a full-time occupation was given a weekly score of 20, a part-time occupation 10.

Confidant. Confidant scoring was based on respondents' answer to the question. How many confidants in your life? If the respondent had a number for confidant's available, this number was coded as a "yes" answer for confidant availability. If the respondent had no number for confidant's available, the absence of a number was coded as a "no" answer for confidant availability. A confidant is someone with whom you can share your most private thoughts and feelings (See Appendix D).

Living situation. Living situation was determined from respondents' selections among four categories of living arrangements, (See Appendix D).

Health. Health was measured on a scale from one to ten with one indicating worst and ten best, (See Appendix D).

CHAPTER 4

RESULTS

This chapter is divided into two major sections: (1) results that directly address the hypothesis and research questions guiding this study, and (2) results obtained from additional analyses performed. These additional analyses explored any possible differences due to interactions among relevant variables.

Research hypothesis

Age, communication apprehension, sex, amount of social contact, confidant availability, health, and living situation will account for a significant amount of variance in loneliness.

To test the research hypothesis, multiple regression analysis was performed in order to regress loneliness on: communication apprehension, age, gender, social contacts, confidant availability, health, and living situation. No significant regression model was obtained; therefore, the research hypothesis was not supported.

Research Questions and Findings

RQ₁: Will there be a significant difference between older and younger people in terms of presence or absence of a confidant?

The univariate F-test performed provided an affirmative answer to this question, ($F=3.94$, $p<.02$). Mean scores indicate that younger respondents ($M=.8889$) reported higher confidant availability than the older respondents, ($M=.7857$). See Table 1.

RQ₂: Will there be a significant difference between the sexes in terms of the presence or absence of a confidant?

The second analysis performed indicated an affirmative answer to this question ($F=7.04$, $p<.007$). The mean score for confidant availability for females, ($M=.8926$) was higher than for the males ($M=.7403$). See Table 2.

RQ₃: Will there be a significant difference between respondents reporting the presence or absence of a confidant and the amount of reported social contact?

An affirmative answer to this question was obtained ($F=5.75$, $p<.002$). These results indicate that individuals reporting "yes" on confidant availability also reported higher social contact scores ($M=16.12$) than individuals reporting "no" on confidant availability ($M=9.0000$). See Table 3.

RQ₄: Will there be a significant difference between respondents reporting the presence or absence of a confidant and their stated health levels?

The fourth F-test performed provided an affirmative answer to this question ($F=11.20$, $p<.000$). These results reveal that respondents reporting "yes" to confidant availability rated higher in their health reported scores ($M=7.18$) than respondents reporting "no" to confidant availability ($M=4.57$). See Table 4.

RQ₅: Will there be a significant difference between older and younger people in terms of their stated health level?

As one might expect, the analysis revealed ($F=8.51$, $p<.000$), a significant difference in health scores between older and younger people. The younger respondents reported higher health scores ($M=7.51$) than the 65+ respondents ($M=5.90$). See Table 5.

RQ₆: Will there be a significant difference between the sexes in terms of their reported loneliness?

The difference obtained approached significance ($F=3.12$, $p<.07$). Females reported higher loneliness scores on the UCLA Loneliness Scale ($M=2.73$) than the males

($M=2.62$). Note: the higher loneliness scores mean the females are reporting less loneliness than the males. The UCLA Loneliness Scale interprets high loneliness scores as less lonely and low scores as more lonely. See Table 6.

RQ₇: Will there be a significant difference between the sexes in terms of their reported social contact?

No significant difference was obtained between the men and women in terms of their social contact scores.

Additional Findings

In addition to those analyses directly addressing the hypothesis and seven research questions in this study, analyses exploring possible interaction effects were performed:

Three-way Interactions:

Five $2 \times 2 \times 2$ (sex by age by confidant availability) analyses of variance were performed on the five measures (CA, loneliness, social contacts, living situation, and health). No three-way interactions were obtained.

Two-way Interactions:

Three 2×2 (sex by age, sex by confidant availability, and age by confidant availability) analyses of variance were performed on each of the same five dependent variables noted above.

No two-way interactions (sex by age) was obtained for communication apprehension. However, the analysis approached significance with ($F=3.36$, $p<.06$), see Table 7.

A significant interaction (sex by age) for health was obtained ($F=4.27$, $p<.03$). See Table 8.

A second significant interaction (age by confidant availability) for health was obtained ($F=5.34$, $p<.02$). See Table 9.

In addition to the above analyses, bivariate correlations were obtained for all variables examined in this study. Significant correlation coefficients were obtained for the following pairs: (1) social contacts correlated inversely with increased age ($r=-.127$, $p<.03$), (2) health correlated inversely with increased age ($r=-.209$, $p<.001$), (3) social contact scores correlated with confidant reporting scores ($r=.211$, $p<.000$), (4) social contact scores correlated with health scores ($r=.140$, $p<.01$), and (5) confidant reporting correlated with health ($r=.254$, $p<.000$); see Table 10.

DISCUSSION

In discussing the findings reported earlier, a number of limitations and qualifications should be noted. This research employed a sample of older citizens obtained from Senior Citizen Centers. Their counterparts were limited to college and university students. No claim is advanced that generalizing to a broader sample can be made.

Since the majority of the elderly researched in this study were found in senior centers, which was an environment conducive to socializing, we need to know more about the elderly who are not attending senior centers.

What are the parameters surrounding the older population? Then what proportion are in a poor state of health and in care homes or in isolating situations, such as living in paid homes located in areas surrounded by predominantly young neighbors? Also, what proportion are living in predominantly older communities? Which living situation creates the healthiest and most opportune communication environment for the elderly in order to promote meaningful relationships?

Despite the limitations and qualifications noted above, these results give insights in several areas. One area is the often discussed issue of the lack of numerous social encounters contributing to loneliness. The number of

social contacts was not reflected in the respondents reported loneliness scores. However, what was found, in this study, was that those respondents who indicated that they had a confidant also reported larger numbers of social contacts. Also, it was very clear that poor health was more likely to be a problem among respondents lacking a confidant.

These findings suggest that the quality of a relationship is more important to an individual's health than the quantity of relationships. Furthermore, a relationship with an intimate invariably leads to increased social contact; however, the reverse is not true. Therefore, it appears social contact skills are not sufficient for confidant initiation and maintenance.

Perhaps the emotional, psychological, and communicative skills needed for confidant sharing are important and similar to behaviors needed to increase social relations.

Furthermore, it seems that confidant-sharing behavior would include trust, risk taking, and self-disclosure. As noted earlier, there appears to be a general consensus that a relationship between trust and self-disclosure does exist (Cozby, 1973; Pearce & Sharp, 1973). There is a host of research that could be interpreted as supporting the notion that increased disclosive communication produces trust (e.g., Deutsch, 1968; Loomis, 1959; Ostermeier, 1967; Worth,

Gary & Kahn, 1969; Wheelless & Gortz, 1975). Jourard (1971) further states that self-disclosure follows an attitude of love and trust. It seems that trust, risk, and self-disclosure skills should be further explored in terms of their relationship to confidant sharing and social contact.

Another area addressed in the study was the relationship of increased loneliness due to the aging process. Surprisingly, loneliness was not more prevalent among the aged. However, poor health was associated with the aging process.

With poor health, the elderly are often immobile and housebound; therefore, they would be unable to seek out new relationships when they become separated from loved ones because of death or relocation. The elderly are more susceptible to these happenings than other populations.

Often the elderly believe the myth that old age and loneliness are synonymous occurrences unavoidably concurrent. By pointing out to our aging population that their loneliness can be controlled, perhaps then they will consider taking steps to alleviate their state of loneliness. Schultz (1976) stated that events that are either predictable or controllable have a positive impact on health status and morale. For the elderly, it is crucial to learn how to establish meaningful social bonding in new

relationships to replace the old relationships which they can no longer maintain.

Even though communication apprehension did not correlate with loneliness (or any of the other variables) in this study, it does appear to be possibly affected by the interaction effect produced by sex and age. This contrast "approached significance." There is a slight but nonsignificant trend toward older women experiencing more communication apprehension than their counterparts.

In agreement with previous research on aging, this study found a significant difference between those reporting confidant availability and the number of available social contacts. Respondents reporting a higher number of confidants also reported larger amounts of social contact.

In the Graney (1975) study, positive relationships were found between happiness and social participation activities among the aged. Increases in activity, over time, were often related to happiness, and declines in activity were related to unhappiness. The declines in activity could be reflected by a decline in social contact, which could then lead to loneliness.

A future longitudinal study is recommended to address the question of whether patterns of relationships with elderly and their confidants shift as a result of losing contact with a confidant because of death, relocation, or poor health.

It may be that persons left without an intimate other will differ in respect to their ability to change their patterns of communication behavior so as to satisfy their needs for social contact and intimate bonding with a new confidant.

In general, satisfying this bonding need is likely to require the acquisition of or the reestablishment of communication skills (perhaps skills which have been dormant for a long time).

Although the research hypothesis predicting a significant regression model was not obtained, a number of significant bivariate relationships were found. Additionally, five out of the seven questions regarding differences were answered at statistically significant levels. Of the remaining two, a difference approaching significance was obtained for one.

There is little doubt that communication in its manifest forms interacts with variables associated with the aging process. The hope is that this study makes a modest contribution to our knowledge of such interactions.

As Graney (1975) has noted "...of the activities highly associated with happiness, most involved face-to-face interaction, or the potential for this" (p. 705).

Finally, Zakahi & Duran (1982) state that a communicative approach may prove to be the most logical and effective approach to the problem of loneliness. "The communication based research seems to be the only research available which addresses methods of dealing with loneliness. By examining the relationship of loneliness to problems which can be treated, an indirect approach to the problem may be found" (Zakahi & Duran, 1985, p. 58).

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APPENDICES

APPENDIX A

TABLES

Table 1

Analysis of Variance, Confidant Availability by Levels of Age

Source	Analysis of Variance				
	Sum of Sqr.	D.F.	Mean Sqr.	F	Sig.
Between Groups	1.2222	2	.6111	3.9358	.0211
Linearity	.2854	1	.2854	1.8383	.1767
Dev from Linearity	.9368	1	.9368	6.0332	.0149
			R= -.0952 R ² = .0091		
Within Groups	30.2778	195	.1553		
			Eta= .1970 Eta ² = .0388		

Table 2

Analysis of Variance, Confidant Availability by Levels of Sex

Source	Analysis of Variance			
	Sum of Sqr.	D.F.	Mean Sqr. F	Sig.
Between Groups	1.0915	1	1.0915	7.0353
*Linearity				.0086
Within Groups	30.4085	196	.1551	
			Eta= .1861	Eta ² = .0347

*With fewer than three groups, the relationship is linear.

Table 3

Analysis of Variance, Social Contact by Levels of Confidant Availability

Source	Analysis of Variance				
	Sum of Sqr.	D.F.	Mean Sqr.	F	Sig.
Between Groups	2346.9604	2	1173.4802	5.7494	.0037
Linearity	1882.2937	1	1882.2937	9.2222	.0027
Dev from Linearity	464.6668	1	464.6668	2.2766	.1330
R= .2113 R ² = .0447					
Within Groups	39800.3578	195	204.1044		
Eta= .2360 Eta ² = .0557					

Table 4

Analysis of Variance, Health by Levels of Confidant Availability

Source	Analysis of Variance			
	Sum of Sqr.	D.F.	Mean Sqr. F	Sig.
Between Groups	222.9653	2	111.4827	11.2037 .0000
Linearity	139.6861	1	139.6861	14.0381 .0002
Dev. from	83.2792	1	83.2792	8.3694 .0042
			R= .2541	R ₂ = .0646
Within Groups	1940.3478	195	9.9505	
			Eta= .3210	Eta ² = .1031

Table 5

Analysis of Variance, Health by Levels of Ages

Source	Analysis of Variance				
	Sum of Sqr.	D.F.	Mean Sqr.	F	Sig.
Between Groups	173.6063	2	86.8031	8.5071	.0003
Linearity	94.2240	1	94.2240	9.2344	.0027
Dev from Linearity	79.3823	1	79.3823	7.7798	.0086
			R= -.2087	R ² = .0436	
Within Groups	1989.7069	195	10.2036		
			Eta= .2833	Eta ² = .0803	

Table 6

Analysis of Variance, Loneliness by Sex

Source	Analysis of Variance				
	Sum of Sqr.	D.F.	Mean Sqr.	F	Sig.
Between Groups	.5491	1	.5491	3.1091	.0794
With fewer than three groups, the relationship is linear					
Within Groups	34.6186	196	.1766		

$$\text{Eta} = .1250 \quad \text{Eta}^2 = .0156$$

Table 7

Two-Way Anova (Sex by Age) for Communication Apprehension

Univariate F-tests with (1,187) D.F.						
Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
CA	1.51878	84.57097	1.51878	.45225	3.35827	.068
LO	0.00261	33.50874	0.00261	.17919	.01457	.904
SOCIAL	2.39009	38566.7599	2.39009	206.23936	.01159	.914
LIVING	2.58705	253.42207	2.58705	1.35520	1.90898	.169
HEALTH	5.35291	1687.18355	5.35291	9.02237	.59329	.442

Table 8

Two-Way Anova (Sex by Confidant Availability) for Health

Univariate F-tests with (1,187) D.F.						
Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
CA	.28286	84.57097	.28286	.45225	.62545	.430
LO	.43395	33.50874	.43395	.17919	2.42173	.121
SOCIAL	11.61174	38566.7599	11.61174	206.23936	.05630	.813
LIVING	.07705	253.42207	.07705	1.35520	.05685	.812
HEALTH	38.55014	1687.18355	38.55014	9.02237	4.27273	.040

Table 9

Two-Way Anova (Age by Confidant Availability) For Health

Univariate F-tests with (1,187) D.F.						
Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
CA	.00020	84.57097	.00020	.45225	.00043	.983
LO	.02571	33.50874	.02571	.17919	.14346	.705
SOCIAL	102.31374	38566.7599	102.31374	206.23936	.49609	.482
LIVING	.02572	253.42207	.02572	1.35520	.01898	.891
HEALTH	48.19517	1687.18355	48.19517	9.02237	5.34174	.022

Table 10

Bivariate Correlations for all Variables in the Study

	CA	LO	SEX	AGE	SOCIAL	CONFIDANT	LIVING	HEALTH
CA	1.000 .999	.049 .248	-.040 .290	.098 .085	-.035 .313	.078 .137	-.066 .179	.058 .209
LO	.049 .248	1.000 .999	-.125 .040	-.060 .199	.022 .378	.020 .392	.040 .289	-.025 .362
SEX	-.040 .290	-.125 .040	1.000 .999	-.076 .145	.058 .208	-.186 .004	.093 .095	.031 .332
AGE	.098 .085	-.060 .199	-.076 .145	1.000 .999	-.127 .038	-.095 .091	-.095 .091	-.209 .002
SOCIAL	-.035 .313	.022 .378	.058 .208	-.127 .038	1.000 .999	.211 .001	.094 .094	.140 .024
CONFIDANT	.078 .137	.020 .392	-.186 .004	-.095 .091	.211 .001	1.000 .999	.111 .060	.254 .000
LIVING	-.066 .179	.040 .289	.093 .095	-.095 .091	.094 .094	.111 .060	1.000 .999	.029 .341
HEALTH	.058 .209	-.025 .362	.031 .332	-.209 .002	.140 .024	.254 .000	.029 .341	1.000 .999

KEY: CA = Communication Apprehension; LO = Loneliness; SEX = Sex; Age = Age;
 SOCIAL = Social Contacts; CONFIDANT = Confidant Availability; LIVING =
 Living Situation; HEALTH = Health.

APPENDIX B

COMMUNICATION APPREHENSION QUESTIONNAIRE

FOR EACH ITEM BELOW, PLEASE CIRCLE THE NUMBER OF THE STATEMENT THAT APPLIES TO YOU BY MARKING WHETHER YOU

STRONGLY AGREE (1)
AGREE (2)
ARE UNDECIDED (3)
DISAGREE (4)
STRONGLY DISAGREE (5)

MANY OF THE STATEMENTS ARE SIMILAR TO OTHER STATEMENTS. DO NOT BE CONCERNED ABOUT THIS. WORK QUICKLY, RECORD YOUR FIRST IMPRESSION.

	Agree			Disagree	
1. While participating in a conversation with an acquaintance, I feel very nervous.	1	2	3	4	5
2. I have no fear of speaking up in conversations.	1	2	3	4	5
3. Ordinarily I am very tense and nervous in conversations.	1	2	3	4	5
4. Ordinarily I am very calm and relaxed in conversations.	1	2	3	4	5
5. I'm afraid to speak up in conversations.	1	2	3	4	5

PLEASE TURN THE PAGE.

APPENDIX C

LONELINESS SCALE

DIRECTIONS: Indicate how often you feel the way described in each of the following statements. Circle one number for each.

Statement	Never	Rarely	Sometimes	Often
1. I feel in tune with the people around me.	1	2	3	4
2. I lack companionship.	1	2	3	4
3. There is no one I can turn to.	1	2	3	4
4. I do not feel alone.	1	2	3	4
5. I feel part of a group of friends.	1	2	3	4
6. I have a lot in common with the people around me.	1	2	3	4
7. I am no longer close to anyone.	1	2	3	4
8. My interests and ideas are not shared by those around me.	1	2	3	4
9. I am an outgoing person.	1	2	3	4
10. There are people I feel close to.	1	2	3	4
11. I feel left out.	1	2	3	4
12. My social relationships are superficial.	1	2	3	4
13. No one really knows me well.	1	2	3	4
14. I feel isolated from others.	1	2	3	4
15. I can find companionship when I want it.	1	2	3	4
16. There are people who really understand me.	1	2	3	4
17. I am unhappy being so withdrawn.	1	2	3	4
18. People are around me but not with me.	1	2	3	4
19. There are people I can talk to.	1	2	3	4
20. There are people I can turn to.	1	2	3	4

PLEASE NOTE:

Page(s) missing in number only; text follows.
Filmed as received.

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APPENDIX D

DEMOGRAPHIC QUESTIONNAIRES

APPENDIX D

63

1. Perception of health, the top of the ladder represents best possible health. The bottom represents worst possible health. Please mark the ladder by placing an "x" on the level which you feel best represents your present state of health.

10	BEST
9	
8	
7	
6	
5	
4	
3	
2	
1	WORST