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# THE APPROACH TO CARE AMONG OLDER PEOPLE LIVING ALONE IN LITHUANIA

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**ABSTRACT** *The Lithuanian context of an increased need for care in old age is framed by the demographic trends, such as population aging, the intense emigration of younger generations, and a significant proportion of older people living alone on the one hand, and on the other the strong support represented by filial duties in respect of care and insufficiently developed social services. How do older people experience and handle the situation? This paper uses qualitative interviews (N=27) to analyze the preferences and experiences of care among older people living alone in Lithuania. Based on the study findings, older people seek to maintain their agency under all circumstances related to care, and informal support is appreciated as providing more such options. Formal social services are rejected for reasons including distrust, the lack of social skills, or the cost and insufficient accessibility of such services.*

**KEYWORDS:** *older people living alone; care; agency*

## INTRODUCTION

The trend of an aging population is observable in many countries. In Lithuania, the share of the population aged 65 and older in 2017 was 19.3% and increased to 19.9% in 2020 (Eurostat 2018). In 2011, the share of the population aged 65 and older and living alone was 33.1%. In the EU, a larger proportion of such individuals were only registered in Denmark, Estonia, Finland, and Hungary

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(Mikulionienė et al. 2018). In Lithuania, most people living alone are women, and more than half of them are widows (Mikulionienė et al. 2018). Old age is associated with an increased risk of health problems, which may require more comprehensive care.

In Lithuania, in 2007, long-term care was defined as the entirety of care and social services by which a person's needs are met (Government of Lithuania 2008). Responsibilities are split between two sectors (health and social services), provided separately. As described in the report by the European Commission (Lazutka et al. 2018), the social component of long-term care in Lithuania includes day-care facilities, home help, elderly residential institutions, and cash-for-care benefits, the latter involving 47.9% of all long-term care beneficiaries. Since cash benefits are paid to people based on their need for permanent care, and no formal rules are available concerning how they should be used, an assumption can be made that a significant portion cover the wages of informal caretakers. While the share of older people aged 65+ and residing in care homes has remained around 1% since 2001, the share of home-help recipients increased from 0.6% in 2007 to 2.8% in 2016. Since 2007, the number of NGOs providing care services has grown (Lazutka et al. 2018).

Local cultural traditions and the lack and inaccessibility of formal care services have given rise to care arrangements for the elderly primarily based on informal networks comprising family members, neighbors, and friends (Lazutka et al. 2018). In Lithuania, the traditionalist attitude that children are responsible for the care of their old parents and should live with them once care is required is prevalent (Gedvilaitė-Kordušienė 2013). Help provided by close relatives is the preferred form of care, and would be chosen if needed by 68% of the Lithuanian population aged 50–65 (Blažienė–Žalimienė 2017). Among the expectations of future service recipients, the emotional relationship and the caretaker's gender, age, and sexual orientation were prioritized over professional qualities (Žalimienė 2019). Currently, care homes are perceived as institutions for older adults rejected by their families (Žalimienė 2019), but attitudes may change as 47% of people aged 50–65 have children living abroad (Lazutka et al. 2018).

Demographic and socioeconomic trends show the decline in the possibility of relying on informal networks. Although traditional culture advocates family care, expressions of filial piety are hindered by the labor-force participation of adult children, geographic mobility, and low fertility rates. Lithuania has experienced intensive migration flows. This was the leading cause of depopulation in 1990–2017, and only in 2019 did the net emigration rate become positive. Since the country regained its independence, more than a million people have emigrated from Lithuania (Official Statistics Portal 2021). Although research findings

indicate that transnational conditions do not eliminate the possibility for migrant adult children to take care of their elderly parents (Gedvilaitė-Kordušienė 2015), care assistance that requires face-to-face contact must be replaced by networks not comprised of children. Within such a demographic context, sources of informal care may be more restricted for people living alone compared to those with other housing arrangements. Previous research on indicators of inadequate access to informal care found that living alone is associated with a greater likelihood of unmet need (Potter 2017; Desai et al. 2001). Potter refers to studies proving that unmet needs are greater among informal rather than formal care recipients. This creates tension between the need for adequate care and maintaining independent living at home in old age.

Most studies that explore care for the elderly in single-person households tend to address quantitatively measured issues, such as the complementarity of formal and informal support (Chappell–Blandford 2008), the trends and situations of older persons living alone (Teerawichitchainan et al. 2015), and the relationship between partnership status and the fact of having (not having) children with support networks (Larsson–Silverstein 2004). Fewer studies consider the absence of a co-residing family caregiver and the experiences and preferences for care in elderly years. Ambiguous findings were revealed by Hanratty et al. (2013), who studied a specific group of the elderly in the UK – namely, cancer patients living at home during their last year of life. Patients viewed living alone as a disadvantage, yet expressed anxiety about moving into a care home. The interviews also revealed the importance of relational continuity with health professionals, informal appraisal of care, and emotional and practical barriers to accessing care. Another qualitative study claimed that informal caregiving in older age tends to be understood as mainly family caregiving, with little attention to non-kin caretakers. Thus, Pleschberger and Wosko (2017) focused not on the experiences of care recipients but on the role of informal caregivers, arguing that non-kin care arrangements might be a vital resource of care in the future. Their study proved the strong commitment of non-kin caretakers to the elderly living alone at the end of their lives in Austria. The main challenges addressed by non-kin caretakers are the burden of increased physical care needs and anxieties associated with death and dying. The authors concluded that these challenges necessitate support from palliative care specialists.

Considering the lack of qualitative research, especially from Central and Eastern Europe, the aim of this study is to investigate the preferences and experiences of care among older people living alone in Lithuania. The applied theoretical framework consists of an analysis of social care on two levels. First, from the standpoint of a welfare state, the article discusses the interconnectedness of care with cultural, institutional, and socio-structural arrangements in society.

The second theoretical part problematizes care linkages with dependency/autonomy dilemmas in later life, referring to a more individual level.

## *Theoretical frame: social care, care arrangements, and intergenerational policy regimes*

Empirically understood as the "paid and unpaid provision of support involving work activities and emotional empathy," the concept of care in social sciences is broad and approached from a somewhat critical perspective (Geissler–Pfau-Effinger 2005). The term "social care" implies the dichotomization of social life into two spheres – private and public. Including care into the private sphere results in the downgrading effect of social care, considering that care traditionally involved the unpaid private work of women (Geissler–Pfau-Effinger 2005; Daly–Lewis 2000). However, women's emancipation and integration into the labor market have not changed the value of care work. Geissler and Pfau-Effinger (2005) pointed to two dilemmas related to social care in this regard. First, even if the expansion and professionalization of personal care service occurs, care activities would still be identified as "feminine" and therefore less well paid, especially in liberal and conservative welfare states (Esping-Andersen 1990). Another dilemma is related to the character of care work itself. Since caretaking is traditionally based on emotional bonds with the people in care, it is challenging to set limits on its formalization and monetarization. The formalization of care has been viewed as the primary strategy for women's social inclusion, and this process means transferring care work from the family household to other environments, often public institutions (Anttonen–Sipilä 2005). In this context, informal and formal care are often conceptualized as opposites: formal care enables women to participate in the labor force and therefore is considered "modern" and "women-friendly," while informal care, contrarily, is associated with social exclusion (Geissler–Pfau-Effinger 2005). However, Geissler and Pfau-Effinger (2005) have problematized this conflict. In the authors' view, the concept of two opposites leaves out the more recent development of informal work. Two new forms of informal care include semi-formal family-based care work and informal care employment. The first form, according to the authors, is based on the linkage of the care relationship in the household to the welfare state – i.e., to tasks related to the care of the elderly undertaken by families or social networks that is compensated by social security ("cash-for-care" welfare schemes). The second is based on informal work agreements, such as employing migrants as caregivers in households. This form of informal care employment has become common in those European welfare

states that restrict the employment of immigrants (Gather et al. eds. 2002). It might become more significant considering the relevant changes in Lithuania – a shift from a migrant-sending to a migrant-receiving country.

Differences between the specific care regimes of various countries can be explained by welfare-state policies that determine social care development. Pfau-Effinger (1998; 2005) explained this variation between countries through the concept of "care arrangement," defined as the underlying cultural, institutional, and socio-structural framework of a society that illustrates the mix of social care and welfare provision. The developers of intergenerational policy regimes explain such variation in the mix of care and financial support as being due to the intersection of state, market, and family. This way, the concept of social care can serve as an indicator of welfare state variation. For example, based on conceptual frameworks by Korpi (2000), Leitner (2003), Leitner–Lessenich (2007), and Saraceno (2004; 2010), Saraceno–Keck (2010) developed a theoretical conceptualization of four different patterns that may be located on the continuum of familialism/de-familialization. The first pattern – familialism by default, or unsupported familialism – reflects the care arrangements that exist in a situation of non-existent public alternatives to family care or related financial support. The second – supported familialism – refers to a pattern of policies that support family members to keep up their financial and care responsibilities. Usually, this support is provided via financial transfers. The third pattern – de-familialization – reflects arrangements when the "individualization" of social rights (e.g., minimum income provision, entitlement to higher education or care) reduces family responsibilities and dependencies (Saraceno–Keck 2010: 676). Finally, the fourth arrangement is a rare case and a variant between supported familialism and de-familialization. Based on researchers who investigated Lithuania's position in this theoretical frame, the normative level of intergenerational responsibilities attributes Lithuania with the pattern of supported familialism (Kraniauskienė 2013). The orientation towards supported familialism is also evident when analyzing the more specific issue of attitudes towards the care of elderly parents (Kraniauskienė 2013).

## *Agency in later life*

According to Sharon Wray (2003), some conceptualizations of later life tend to focus on negative aspects associated with aging, drawing parallels with care-related issues such as loss of self-autonomy and independence. The researcher provided examples of several theories that previously dominated gerontology,

based on conceptualizations such as role theory and disengagement theory. Both theories maintain that aging requires the cessation of previous roles and activities and disengaging from society. Retirement and widowhood are considered the "natural" transition in later life; thus, the theories ignore agency and empowerment. The opposing stance is taken by authors that focus on the positive aspects of growing older. One empirical example may be the study by Terrill and Guillifer (2010) that illustrates how women experience an increase in freedom in later life, enabling more choice of activities and emphasizing the possibility of liberation and resilience and growth in later life. Usually, what is common direction to such an approach is breaking down the stereotypes associated with old age and an emphasis on the ability to manage the aging process (Wray 2003). The theoretical example of such an approach may be activity theory, which considers remaining active as successful aging (Wray 2003; Wilson 2000). Originally proposed by Havighurst et al., the theory suggests that older adults go through a more successful aging process by maintaining social interaction and their productive role in society (Versey 2015). The concept of the "third age" ("young old age") may be an illustration of this type of approach (Wray 2003). Laslett's (1989) book *A Fresh Map of Life: The Emergence of the Third Age* made this concept a mass phenomenon. Soon, popular literature took up the concept, advocating active engagement during later life and defining an emerging group of individuals who possessed unique capacities to engage in society because of their better health and employment status (Carr–Komp 2011). The third age allows for the maintenance of autonomy and agency due to an increase in affluence, individualization, and the de-institutionalization of the life course (Gilleard–Higgs 2010). Contrarily, the fourth age is associated with dependence and decrepitude (Laslett 1989). Wray (2003: 515) considered this approach problematic because "it does not challenge commonly used conceptual measures, such as the quality of life and empowerment, and consider how they change across culture." Laslett also did not elaborate on what constitutes agency in later life.

Based on the current research, the concept of agency in old age is considered somewhat problematic. The term "agency" can be defined as the "ever-present possibility of individuals to act in a way that generates feelings of power and control, it is not something that people either do or do not possess" (Wray 2003: 514). Kabeer (1999: 438) defined the term as the "meaning, motivation and purpose which individuals bring to their activity." When others deem a person as no longer being able to manage everyday life, this leads to the loss of social agency (Gilleard–Higgs 2010; 2014). The "old-old" ("fourth") age can be treated as a state of "unbecoming" (Higgs–Gilleard 2014). This view is shared mainly by older people, who associate agency with autonomy in decision-making and

the ability to do things without external assistants (Jolanki 2009). Independence – the ability to do things as before, to have control over one's own affairs, which is linked to good health and an active lifestyle – is an important concept related to such autonomy in older age (Fenton 2014).

The need to preserve autonomy and independence may contradict care-related needs, especially for people living alone. Nevertheless, agency does not end completely with the need for care in old age. Care services differ according to the level of restriction they impose on the recipient's autonomy (Greene 2000). Care services range from the least to most restrictive of a person's autonomy. In this respect, care services provided at home are the least restrictive, followed by community services (i.e., day centers), while the most restrictive form is institutionalized care (Greene 2000). However, even in the last case, some agency of an older person may be maintained by involving them in the selection of a care home. Maintained autonomy is related to the activity, self-esteem, health, and quality of life of an older person, while the loss of power and control are related to elevated feelings of uselessness and depression, and mortality (Hellstrom–Sarvimaki 2007). This study deals with older people of the "third age," who often have limited mobility but can make decisions independently and take care of themselves with some external support. While analyzing care experiences and preferences among these older people living alone, the study investigates how agency is incorporated into narratives and arguments about the de-prioritization of formal care.

## DATA AND METHODS

This study involved conducting qualitative semi-structured interviews with older people living alone (N=27) in Lithuania. The selection criteria specified nonworking permanent residents of Lithuania, aged 60 and above, in community-dwelling and single-person households. Informants were included in the study according to different characteristics – gender, age, marital status (i.e., single, widowed, divorced, with children, childless), education, place of residence, ethnicity, and duration of living alone (See Table 1 in the *Appendix*). The informants were interviewed in the Lithuanian, Russian, and Belarusian languages. The fieldwork was conducted from June to August 2017 in urban and rural areas of Vilnius, Ignalina district, and Raseiniai town and district.

The study was implemented following the fundamental ethical principles of anonymity, privacy, and confidentiality. Codes were assigned to participants to protect their anonymity.

Qualitative content analysis (Hsieh–Shannon 2005) and an inductive coding method (using the software Maxqda) were used. Initially, two coders (including the second author) created a preliminary code tree. Subsequently, the entire material with various topics related to living alone was coded by one researcher based on a previously harmonized code tree and by adding in vivo codes. Next, the material was reviewed and corrected (if necessary) by another investigator (the first author). This study examines only the segments about care, which were further analyzed by the first author using the principles of grouping and condensation based on similar values.

## FINDINGS

The study findings revealed a contradiction: older people living alone receive rather a lot of help every day, but deny the need for (additional) help, especially rejecting formal care services. This contradiction will be revealed in detail in the following sections, in which we will discuss the care received by the older people living alone, their unmet need for help, and arguments for rejecting formal services.

### *Care received by older people living alone: from family to formal services*

Most support for older people living alone is provided **at home**, usually by their children, families, and neighbors. When asked about help, some informants use abstract and unspecified language, only mentioning the helpers:

> *...it's the sister, it's the daughter, she lives nearby, so she helps me. (20MIc[2])*
> *[My]children are close by [....] it makes all the difference to have close relatives. (23MIIa)*

Also, 1WIIc (son helps), 17MIIc (neighbors), 22MIIa (daughters, grandchildren), and 25WIIc (daughter, son-in-law).

2 All informants were coded using Arabic numerals 1–27 = number of the interview; letters W = woman or M = man; Roman numerals I = aged 70 or less, II = aged 71 or more; small letters: a = less than 3 years living alone, b = 4 to 13 years, and c = more than 13 years living alone.

Others mention the work done by close relatives: this includes food provision and laundry (8MIa, 18WIIc, 19MIIc), house cleaning (19MIIc, 21MIIc), window cleaning (4WIIb), gardening and planting (18WIIc). Food provision is especially relevant in the countryside, where neighbors (17MIIc) or a visiting relative (17MIIc, 27WIIc) often bring the necessary products from the city. Remote homesteads are visited by a private-car-based ‘shop’ (6WIc). In villages, neighbors help to bring well-water and firewood (18WIIc), carry heavier items (25WIIc), and provide transportation in case of need (16WIIa, 24MIIb, 25WIIc). Home help is especially needed in the case of illness: *[they] come, bring, buy...* (5WIa), caring for chickens, and starting a wood-burner (26WIIb). The older villagers are occasionally (during major holidays or every few months) taken to church by their children (18WIIc, 21MIIc).

The gendered nature of care provision was identified, preserving traditional masculine and feminine roles. Men living alone are helped with housework by women in the neighborhood – i.e., support with washing the floor, picking berries, and tidying up (21MIIc, 24MIIb). Women living alone more frequently mention the need for help with so-called “men’s work”; namely, small repairs at home (2WIc, 4WIIb, 9WIc), pruning in the garden (11WIIc, 3WIIc), and firewood preparation (26WIIb). Help is provided by relatives, friends, and neighbors. Not all women have such helpers close by, so the search can become tedious:

> *I look for a man. Yes, this depresses me the most. [...] Yes-yes-yes, any trifle. [...] Men’s work is the most depressing.... (9WIc, 2WIc)*

Acquaintances are employed in finding a handyman to repair the washing machine or a plumber (4WIIb). One woman willingly hires an alcoholic helper (16WIIa) for larger repair work, while another complained that there are only alcoholics residing in the countryside and nobody is available to do jobs (6WIc). It seems that the informants have agency in searching for help, but in some cases the choice of help options is restricted by the realities of the countryside, reflecting deeper social problems. However, some narratives illustrate that informal help does not necessarily conform to the needs of elderly people living alone (i.e., difficulties finding help requiring physical strength).

A separate group of frequently provided services is related to **health care** – i.e., calling an ambulance, giving a ride to a health-care institution (6WIc, 18WIIc), accompaniment when visiting a doctor (11WIIc), translating into Lithuanian (13WIIb), visiting a hospital, buying (10WIIc) and injecting medications, and measuring blood pressure (16WIIa, 17MIIc), etc. In these cases, assistance is also usually provided by children, close relatives, friends, or neighbors. An

emergency call to a hospital seemed to be taken more seriously when executed by a daughter. Then everybody seemed to be more attentive:

> *Of course, the daughter... Then everybody comes! [...] I myself, when I feel unwell, I call, so, sometimes it [an ambulance] comes, and they say: "No... ma'am, take some drops and ... Take something for your nerves and sleep!" That's all! [...] If she [the daughter] calls, at least the ambulance comes, and then she talks to them and all that. And then they [the medical personnel] speak differently, and then they come. Someone else calls, someone else calls, not me. It is completely different… (15WIIc)*

Children who live far away get involved in the case of more serious health problems, such as surgery or nursing care, while small daily services are provided by neighbors (3WIIc, 4WIIb, 18WIIc).

Only one informant spoke about receiving **formal services** (27WIIc) (the only informal support she receives is financial – from a niece living in a different town). A visiting social worker carries out similar everyday tasks, from buying food or taking the informant shopping and tidying the home to calculating and paying utility bills. It is noteworthy that the informant wants to participate as much as possible, whether through a desire to feel independent or because of distrust:

> *In short, she buys [things] for me when she comes [...] sometimes I go [with her]. It's better for me somehow, I see how much I pay, how much is everything, if I go together. (27WIIc)*

Another research participant said he had a phone number to call in case he wanted social services (21MIIc). Both cases illustrate the need for older people to maintain their agency in relation to formal services.

Thus, as data reveals, the range of informal services received by older people living alone is somewhat broad. Since a significant part of this consists of services that are needed often, including the delivery of food and medicines, cleaning, bringing water, firewood, or different heavier items, and going to the doctor's, they appear to occur frequently or at least regularly during certain periods (such as times of illness). The main assistance providers are children, but other informal networks are employed as well, including neighbors, other relatives, and friends. Support received by older people living alone could be viewed as organized in layers. The first and most common providers of any help are the children of older people, other close relatives, such as spouses of their

children, grandchildren, nephews, and nieces. When children live far away, older people rely more on the daily support of neighbors or friends. The question arises whether older people living alone have additional care needs.

## *Unmet need for support*

The unmet need for services was not well articulated in the data set. The participants of the study missed **less well-defined help**; namely, for someone to come (14WIc), *to help with something [...]. Or [to] find something, let's say, that I can't find myself.* (9WIc) This assistance could be coordinated by a local municipal department – e.g., by providing "male" household work (9WIc).

Three participants expressed the need for **financial support** (10WIIc, 15WIIc, 18WIIc). Services provided at home are relatively expensive, given the minimal budgets of pensioners (15WIIc). Ideally, assistance at home is desired but unaffordable. Again, agency is restricted by limited choice. One informant proposed a social policy that would be helpful in her situation – namely, **covering the travel costs** of her daughter, who regularly comes to help (18WIIc).

There were complaints about the lack of specific **targeted information** regarding provided social services (12WIIb, 15WIIc). However, some people know about the services, although they do not need them yet (4WIIb). One case illustrated the need to be cautious when assessing the awareness of older people about services. To the question of whom she would ask for help in the case of need, the informant answered she did not know if she was entitled to anything and started asking the interviewer about this. However, a further conversation revealed that she was well informed about the services that could be provided and even took care of them for her neighbor (14WIc). Thus, the lack of information in this case was rather related to help she could possibly get in case of need.

Reflecting on the less articulated unmet need for care, silence in interviews often expressed an inability to answer a question or a change of topic, and this could be considered due to internalized social norms (Morison–Macleod 2014). As already mentioned, the social norm of the duty of children to take care of their parents is highly prevalent in Lithuania; thus, informants with children faced difficulty acknowledging their unmet care needs, which could be interpreted as blaming their children for not following these norms.

## *Rejection of formal services: a strategy for maintaining independence*

The spectrum of motives for rejecting formal help is somewhat broad. Some study participants still had good health and did **not need any support**, so they did not inquire about the possibilities available:

> *Actually, no, I did not inquire. I have not needed them yet. (2WIc)*
> *I did not think – I never applied. (11WIIc, 10WIIc)*

Others were a bit more cautious, saying they were still coping without any help:

> *Thank God, I can still manage. And I go to the pharmacy, and I go to the doctor, the clinic is close. (13WIIb, 12WIIb)*

The third group of respondents did not provide specifics; perhaps they were **proud:** *I do not need any services…* (19MIIc); modest: *I don't need anything. It is enough for me…* (3WIIc), or too shy and afraid to 'cause problems' for others:

> *I applied nowhere. I applied nowhere. [...] I do not ask my children, I do not also bother my children – one son also does not work, and now he gardens himself and weeds because his wife does no work at all. (26WIIb)*

When asked about services, one informant understood them as financial support and said she did not ask for anything as she had had a good salary and pension for several years, so she had remodeled her home (25WIIc). Another informant also understood potential support as financial and **degrading**:

> *I have never asked and will not ask for any support from the government to reduce the price of water for me, to give me an exemption, I have never asked for anything. I earned it. I pick berries, I sell them, I do not complain, I have enough, I knit gloves in winter, I sell them, I earn, and for me to whine that it is very hard, that I need money. I have always had and still have enough. (3WIIc)*

An explanation that staying active is being **healthy** sounds similar:

> *I have no problem, you know, I am fully provided for, still healthy, and I need physical activity. If I sit like this, it hurts here, there… once I do some physical work or digging, weeding in the garden, my back doesn't hurt, nothing! Now, I pick blueberries for twelve hours, and it is nothing for me – a whole day in the forest. I am used to physical work. (3WIIc)*
> *So, they would come to me? But then you would do no moving at all, no moving at all but waiting for someone to come, so, it is better to get out somewhere, it is better to do some moving after all, isn't it? (5WIa and 6WIc)*

Others confirmed not needing formal services because help provided by **children and neighbors** was more acceptable:

> *For now, my darling daughter still provides for me [...] So, there is no service, there is this... social worker, one, but what can she... what can she [do] – would she cook for me? (smiles) (8MIa and 1WIIc)*
> *In case of trouble, I'd get it [support], but now when I have a daughter, I don't know if it is worth it. It would be better if my daughter looked after me. If there was trouble, if I was bed-bound, then maybe my daughter... I don't know, I can't say, the daughter should say. (26WIIb, also 24MIIb)*

Support from neighbors through naturally emerging relationships does not seem to threaten independence and self-esteem, unlike potential formal help. The ability to make decisions even concerning one's minor daily routine is a way to preserve autonomy:

> *Nothing so far, no. Not much... **I choose myself what**... what food is needed. I write a note [to neighbors] what to buy, that's all. [...] [At] Christmas and Easter [...] a note came from Caritas to come and eat dinner, there... Then I said again, I still can go to my neighbors to eat. (17MIIc)*

A significant number of responses showed mistrust in the government, social workers, and interaction services by phone offered to older adults. On the one hand, mistrust in the government may be expressed abstractly:

> *There is nothing to expect from the authorities. (20MIc)*
> *Somehow I do not trust the authorities. You will get no support from them. (13WIIb)*

Mistrust in the government may also be grounded on betrayed confidence due to the failure to index pensions and dramatically reduced purchasing power (15WIIc). The lack of confidence in Silver Line, an interaction-by-phone service for older people provided by a non-governmental organization, seems to indicate a general fear of contacting strangers, especially if there is a presumed possibility of intimacy:

> *You know, I do not trust all of them. I simply do not trust them. (16WIIa) and…*
> *Sweetheart, no for sure (smiles). I will not be looking for such things, no. No. No need. [That's] for lovers (smiles). (8MIa)*

Mistrust in social workers is similar; sometimes respondents just stated this pure fact, and in other cases they were concerned about social workers being strangers:

> *Oh, I don't want those social workers! (10WIIc)*
> *And just to come from the social [department], for a couple of hours... Well, when I don't know [her], neither she knows me nor I know her, well, there is no... [...] Well, I don't either have the courage, or comfort, or anything. So, I think in such a case it would be better to go to Ariogala [a care hospital]. (18WIIc)*

It is difficult to guess the real reasons behind the refusal of care, although percolating distrust can be felt, and probably involves discomfort associated with an unfamiliar social relationship:

> *So, now this woman has been assigned to me for two hours a day. Well, now I say what is she going to do here? She will not go outside, there is no space, nothing. She will not collect strawberries, nor berries there, she will not go anywhere. What will she cook? So well, what do I have now, my son will have to go and show her what I have here. I still cook for myself, I make eggs for myself. [...] So no, I refused only temporarily, I only wanted to clear up a bit. (21MIIc)*

Finally, social services were perceived as costly and unaffordable on an everyday basis. Services provided by social workers were considered relatively **expensive** (15WIIc) and entailed a long waiting period:

> *No, you know, for me not yet, no, I have not applied yet, no-no-no. Not to the local municipal department, I called the local municipal department some time ago, [...] they make you queue, they have many people ... (9WIc, also 7MIIa)*

Thus, older people do not expect authorities to take care of them in the case of need. Formal social services are rejected to preserve autonomy and self-esteem, and informal services are prioritized. Often, distrust is a factor, both in general and more specifically of social workers. Also, services may be unavailable due to a lack of social skills, cost, or inaccessibility.

## DISCUSSION AND CONCLUSIONS

The study findings revealed a contradiction: older people living alone receive a broad range of informal services. A significant part of these are provided regularly; however, their need for (additional) care is not articulated, and the possibility of using formal services is actively rejected.

Care for older people is organized in "layers" based on preferences: first, children and family, then neighbors and other relatives and friends, followed by formal care at home. The priorities reflect well the level of agency that can be maintained with each form of care. The findings are consistent with previous studies: formal care is used when informal support is insufficient to cater to needs (Litwin–Attias-Donfut 2009).

The findings also illustrate the paradox of the traditional fear of becoming a burden (Peters et al. 2006) and mainly relying on informal care (Lee et al. 2020). Despite this fear, most help is provided by informal caretakers. These findings resonate with a quantitative study in Canada that found that less than a fifth of respondents relied solely on formal care (Lee et al. 2020).

Remaining at home at an older age to maintain independence can be considered an important achievement of contemporary society. However, tensions emerge together with increasing care needs. A conflict arises between the need for care and support and the wish to remain in control and maintain independence. This issue is even more sensitive for people living alone. Another conflict is related to the roles and responsibilities shared between the state, family, and the older person (Fenton 2014).

The interviews with older people living alone revealed the strong need to maintain agency. Even when informants receive social services, they seek to preserve autonomy in their daily care routines. However, only a few informants

received formal help. Most informants had not received such assistance, and do not expect it to be provided by the authorities. They strive to maintain their agency under various circumstances by rejecting formal services or seeking the desired emotional relationships with caretakers. Agency is a strong argument for refusing formal social services. Such rejection is perceived as preserving of autonomy and self-esteem and avoiding the stigma of being a dependent. Distrust is another reason behind the preference for informal care. It can be felt toward the social support system in general and social workers more specifically. On the one hand, the distrust of state support could hide a fear of state control that is due to the experience of a Soviet totalitarian regime, which made no distinction between the public and the private spheres (Norkus 2008). However, it might be a broader phenomenon, as a fear of being controlled and seeking to remain autonomous are also factors that influence the decision to reject or stop using services by recipients outside Lithuania (Büscher et al. 2010; Snowden–Yamada 2005). On the other hand, distrust in care services that manifests in expressions similar to "a fate worse than death" might refer to an unfavorable cultural environment significantly shaped by media over-representation of bad news stories (Innes 2002), revealing a need for further research in this area.

The significance of the social context also manifests through strong norms of filial duty, shaping the expectations and behaviors of older people in relationships associated with care. Only childless older people with no access to informal assistance accept formal services provided by social workers. The data analysis resulted in different subjective arguments for the rejection of formal services. The prevailing reason is not needing assistance; however, this stance is contradicted by the preexisting broad variety of help provided by family members, close relatives, and neighbors. Along with negative attitudes towards formal support, some informants emphasized the limitations of the formal social support systems, such as the cost and unavailability of services provided at home. Informant suggestions for improving the social support system considering their situations (which correspond to the semi-formal type of care) illustrate the need for personalized social services. These findings are consistent with previous research. The rejection of formal services in Lithuania has been related to the prioritized sociocultural norms of filial duty, distrust, and fear of letting in someone unknown, as well as the high cost and long waiting time to access formal services (Tamutienė–Naujanienė 2013). It is important to note that the lack of information about social services provided in Lithuania is related to the lack of services (Tamutienė–Naujanienė 2013).

Rejecting formal services and relying on support from the informal sector tends to broaden the support network outside the family and close relatives. Members of the local community – neighbors and friends – are also involved in

care networks, especially in rural areas. Such findings complement Pleschberger and Wosko's (2017) research on the vital role of non-kin caregivers, considering such arrangements as an important resource in care provision. This type of community care renders the possibility to receive help at home – the preferred place of care. Friends and neighbors can essentially contribute to the well-being of older adults (Pleschberger–Wosko 2017). However, context-specific reasons may be behind the problem of unmet needs. Considering that rural areas of Lithuania are dealing with rapid aging, some informants lack physical strength and need help. This necessitates the development of social policies adjusted to the needs of older people living alone and their support networks.

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# APPENDIX

***Table 1.*** *Characteristics of informants*

| Characteristic | N |
|---|---|
| Total number of informants | 27 |
| Gender | |
| Woman | 17 |
| Man | 10 |
| Age | |
| 60–70 years | 8 |
| 71–92 years | 19 |
| Education | |
| Primary | 5 |
| Secondary | 13 |
| Tertiary | 9 |
| Employment status | |
| Old age pension benefit recipient (unemployed) | 27 |
| Household type | |
| One-person household | 27 |
| Duration of living alone (the last episode, if multiple) | |
| Less than 3 years | 6 |
| 4–13 years | 5 |
| 13 years or more | 16 |
| Place of residence | |
| Vilnius (capital city) | 13 |
| Mid-sized town | 6 |
| Rural area | 8 |
| Presence of children | |
| With children | 17 |
| Childless | 10 |

*Source: Compiled by authors.*