Loneliness, social isolation and living alone in later life: full report

Background

An enduring theme in social gerontology over the last fifty years has been the positive relationship between social engagement and participation and ‘quality of life’ in later life. This relationship has been exemplified in idealistic terms by proponents of both activity theory and theories of successful ageing (Havighurst 1963; Rowe & Kahn 1997; Rowe & Kahn 1998). The importance of social networks, particularly family and kinship relationships, has consistently been reported by older people as an important factor in the quality of their lives. This consistency has been confirmed using different methods and techniques. In surveys older people have been asked to rank the aspects of their lives which are important to their quality of life. Bowling (1995) found that family and friends were ranked second in importance to health. O'Boyle et al. (1989) using a social judgement technique produced similar results. Farquhar (1995) in a qualitative study found that older people reported that family, activities and social contacts were the three most important factors which gave ‘quality’ to their lives. Reduced social contact, being alone, isolation and feelings of loneliness were associated with reduced quality of old people’s lives. Consequently understanding the extent of isolation and loneliness amongst older people, and the factors associated with these states, is important in both theoretical and policy terms, for developing our understanding of quality of life in later life.

The conceptual confusion between inter-related concepts: living alone, social isolation and loneliness has long been recognised (Townsend & Tunstall 1968). Living alone is the most objective of the three concepts and refers simply to people living in separate households (as defined by national Census data). In 1998, 25% of those aged 65-69 lived alone and 62% of those aged 85 or over (Bridgwood 2000). Living alone has increased markedly in the last 40 years and solo living is expected to continue rising among the older age groups. Living alone is, at every age group, much more common amongst women as compared with men. Social isolation relates to the integration of individuals (and groups) into the wider social environment. This concept includes quantitative ‘objective’ measures of the number, type and duration of contacts between individuals and the wider social environment. A key component of isolation, therefore, is the size of an individual’s social network (Wenger et al. 1996). Loneliness is the subjective evaluation by an individual of their level of social contact and is sometimes characterised as being the counter part of social support (Andersson 1998). Most important here seems to be the social support provided by a close confiding relationship (Bowling 1994). Many social surveys of older people often include some measures of social isolation or loneliness but none since the 1950-60s have focused on them (Townsend 1957; Tunstall 1966). Most survey estimates suggest that the majority is neither lonely nor socially isolated. Major British community surveys have reported rates of loneliness ranging from 5% to 16% with a median of 9-10% (Victor et al. 2000). These levels of reported loneliness are somewhat lower than that reported by younger people and are lower than those reported for some other parts of Europe (Walker & Maltby 1997).

The presence of large social networks does not necessarily imply the presence of a confiding relationship or protection from feelings of loneliness. Likewise living alone is not necessarily synonymous with reported loneliness. Solo living, social isolation and loneliness are related but not co-incident categories (Wenger, Davies, Shahtahmasebi, & Scott 1996). There are however similar social forces associated with each of these
concepts including: personal characteristics (e.g. personality and coping), demographic characteristics (age, gender, marital status) and life events (e.g. bereavement, retirement, migration) (Victor, Scambler, Bond, & Bowling 2000).

This project was conducted in order to address a number of limitations of previous research:

**Family and household change.** There has been significant social change in the last 40 years, not least in terms of living arrangements, family and friendship networks, which may have impacted on social isolation and loneliness.

**National perspective** Recent studies have been conducted in specific geographical areas (e.g. North Wales and East London) and may lack generalisability.

**Conceptual confusion.** Traditional survey methods may have perpetuated the public account (Cornwell 1984) of isolation and loneliness. Little attempt has been made to investigate the value and meaning of the concepts to older people themselves. Measures of isolation that focus on direct contact with family members may be inappropriate and underestimate the importance of indirect contact (e.g. telephone, E-mail).

**Adopting a life course perspective** The failure to adopt a ‘life course’ perspective by distinguishing between those who have always been social isolates (or lonely) from those who recently became isolated (or lonely) confounds understanding. In policy terms these are two distinct groups.

**Predictors and explanations for isolation and loneliness** are relatively poorly investigated in earlier British studies and the North American experience may not be generalisable to the UK. The lack of appropriate statistical tools may in the past have militated against the sophisticated modelling of factors predicting isolation and loneliness, which is now feasible.

**OBJECTIVES**

The aim of this project was to contribute to the theoretical understanding of later life by examining the meaning of isolation and loneliness to the individual and by examining the relationship between loneliness, social isolation and living alone and to contribute to policy and practice by identifying factors protective against isolation and loneliness. Our specific objectives were:

To describe the prevalence of social isolation and loneliness amongst older people living in the community, by the collection of survey data and ‘depth’ interviews. *This objective was successfully addressed (see 3.2.1).*

To contribute to our understanding of secular trends in the experience of quality of life amongst older people by comparing our results with the 1963-4 four-centre survey conducted by Tunstall (1966). *This objective was successfully addressed (see 3.2.1).*

To contribute to knowledge and understanding of later life by investigating the relationship between loneliness and social isolation and living alone for older people. *This objective was successfully addressed (see 3.2.2).*

To contribute to policy and practice by identifying the factors, resources and coping mechanisms that protect older people from experiencing loneliness and isolation. *This objective was successfully addressed (see 3.3)*

To contribute to research methodology by evaluating the effectiveness of using older people as survey interviewers in studies of older people. *(This objective was not subsequently addressed as a result of changes to the research protocol [see 2.2]).*
Methods

STUDY DESIGN

Two-stage follow-up of a random sample of 1299 people aged 65 or over living at home in Britain during a 12-month period responding to the Office of National Statistics Omnibus Survey. Stage 1 comprised structured face-to-face interviews with 999 consenting respondents from the index ONS Omnibus survey. Stage 2 comprised a qualitative in-depth interview with 45 participants, theoretically sampled from Stage 1 to reflect different environments in seven areas in England.

CHANGES TO PROTOCOL

Our original intention had been to undertake a two-stage study employing quantitative and qualitative methods within the four areas of England included in Tunstall’s (1966) study of loneliness. Following the award of the grant the opportunity arose to share the purchase of a ‘Quality of Life’ module of questions within the ONS Omnibus Survey with two other projects: ESRC Growing Older Programme (ESRC GO) project (Adding quality to quantity: Older peoples views on their quality of life and its enhancement led by Prof. A Bowling) and MRC Health Service Research Collaboration programme (Disability and older people led by Prof. Shah Ebrahim). There was substantial benefit to the ESRC GO in doing this, in particular, an increase in the sample size and the harmonisation of questions within the quantitative component of the two GO studies. An added advantage was that the survey fieldwork was conducted by ONS to their high standards thus allowing the two GO project teams to concentrate on the quantitative analysis and qualitative aspects of both studies. This substantive change to the original proposal was agreed with the Programme Director. One aspect of this change in protocol was the inability to directly involve older people in the survey interviewing as originally proposed.

METHODS OF DATA COLLECTION

Index survey

The index survey was the aggregated data from four waves of the ONS Omnibus Survey (OS) carried out in April, September, November 2000 and January 2001. The OS is a face-to-face structured interview conducted with approximately 1,000 adults aged 16 or over in their own homes undertaken monthly (or bi-monthly depending on customer demand). At each wave 30 addresses are randomly sampled from 100 postal sectors across England, Scotland and Wales. This provides a relatively large, nationally based, representative sample of the adult population resident in the community. Each wave includes a standard set of questions on demographic and socio-economic aspects of respondents and their households and additional questions commissioned by customers.

Stage 1 follow-up survey

Respondents in the index survey aged 65 or over were invited by ONS to participate in our shared ‘Quality of Life’ module which was administered at a second interview. The index survey respondents were selected from the four waves over the twelve-month period to control for seasonal effects and to generate sufficient statistical power. Those who agreed to this further interview were reinterviewed two months after the initial contact in June and November 2000 and January and March 2001. The ‘Quality of Life’ module included questions on loneliness and isolation (based on the original questions
used by Sheldon (1948) and Tunstall (1966)); measures of social activity and social contact used by the General Household Survey (Bridgwood 2000), measures of disability and health status (Bond & Carstairs 1982), locomotor disability (Martin, Meltzer, & Elliot 1988), use of services and quality of life (Bowling & Windsor 2001).

**Stage 2: follow-up qualitative interviews**

The qualitative interviews were conducted with 18 men and 27 women aged between 65 and 90 years. Participants were theoretically sampled from respondents in the follow-up survey using the following characteristics: geographical location, age, gender, ethnicity, socio-economic status, living arrangements and type of housing. Initially five areas in England were selected to replicate the sampling frame of Tunstall (Tunstall 1966). These were the South Coast (typical retirement areas), East Anglia and the South West (Rural and retirement areas), the East Midlands and the North East (urban and industrial areas). Following the pilot study (Victor et al. 2002) London (a multi-cultural metropolitan area) and Surrey (an affluent commuter belt) were added. An interview topic guide was generated following experience of the pilot study. Box A summarises the key areas of questioning.

**Box A Summary of topics in interview guide**

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>Preference for social contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living arrangements</td>
<td>Experience of loneliness</td>
</tr>
<tr>
<td>Time in current dwelling</td>
<td>Definition of loneliness</td>
</tr>
<tr>
<td>Time in current neighbourhood</td>
<td>Changes over time</td>
</tr>
<tr>
<td>Close family-children</td>
<td>Health and mobility</td>
</tr>
<tr>
<td>Pet ownership</td>
<td>Impact of ill-health and disability</td>
</tr>
<tr>
<td>Typical weekday</td>
<td>Preference for how spend time</td>
</tr>
<tr>
<td>Weekend</td>
<td>Satisfaction with social activity</td>
</tr>
<tr>
<td>Contact with family</td>
<td>Satisfaction with social contact</td>
</tr>
<tr>
<td>Contact with friends</td>
<td>Satisfaction with social resources</td>
</tr>
<tr>
<td>Significant other or confidante</td>
<td></td>
</tr>
</tbody>
</table>

**Methods of data analysis and interpretation**

**Survey data**

The survey data were subject to both univariate and multivariate analysis. Descriptive analysis of the prevalence of loneliness and social isolation and the patterns of associations with specific risk factors used non-parametric statistics including the Chi-squared test and Mann Whitney U test. Individual risk factors were grouped into five categories: socio-economic factors, health resources, material resources, social resources and social network factors. Ordered logistic regression was used to test the independence of association between these independent variables and the dependent variable (loneliness).

**Qualitative data**

All of the interviews were transcribed in full and coded according to the thematic framework developed through the pilot study (Victor, Scambler, Shah, Cook, Harris, Rink, & de Wilde 2002). Summary sheets were then produced for each transcript highlighting the key themes and factors participants identified as causing loneliness. For each participant summary data of key variables such as socio-economic circumstances were abstracted from the quantitative database from the Stage 1 follow-up survey to facilitate comparison between the qualitative and quantitative data. Independent coding and analysis of a sub-sample of interviews by three members of the project team (SJS,
CRV, JB) checked the validity of the coding and analysis. Coding was found to be consistent and the same themes were identified independently by each researcher.

Qualitative and survey data

Analysis of the two kinds of data was undertaken independently. Preliminary analysis of the qualitative interviews was used to inform the strategy for the multivariate analysis of the survey data. Insights gained from the multivariate analysis, in turn, informed further qualitative analysis.

Results

SAMPLE CHARACTERISTICS

Response rates

An audit trail of study respondents (Stage 1) and participants (Stage 2) is shown in Figure 1. The index Omnibus Survey randomly selected 12,000 addresses in the four waves. Of these 1,089 was ineligible leaving 10,909 eligible to participate in the study. From the 6711 responding addresses, a response rate of 62%, 1323 were identified as containing at least one person aged 65 or over in which consent for inclusion in the follow-up survey involving the 'Quality of Life' module (Stage 1) had been obtained. At follow-up 24 addresses were found to be out of scope, leaving 1299 in scope. At these addresses people aged 65 or over were present and one older person was randomly sampled from each in-scope address. Of these 243 (19%) subsequently refused to participate in the follow-up survey and 57 (4%) were not contactable. The base number of respondents in the follow up survey is 999; a response rate of 77%.

For the qualitative study (Stage 2) 68 respondents were theoretically sampled. Of these 15 refused (6 for health reasons, 6 did not state a reason and 3 reported that they were 'over-researched'), 6 were not contactable, 1 had moved and 1 potential respondent was wanted by a colleague for their research. The number of participants in the qualitative study is 45: a participation rate of 66%.

Non-response bias

Attrition and non-response in follow-up surveys of older people frequently exhibit non-response bias (Gregson et al. 1997; Kelsey et al. 1989; Norris 1987; Rockwood et al. 1989). Older adults, members of ethnic minorities, people with cognitive or communication impairments and people with poor physical or mental health are often under represented. The characteristics of study respondents, however, approximate to the older population of Britain as reported at the 2001 Census and 1998 General Household Survey (Bridgwood 2000). More specifically our study group demonstrates a similar age, sex and household status profile as the general population. Morbidity levels are also similar but we have a slight over-representation of the widowed and homeowners (Table 1). However it is acknowledged that the comparator sources of data are likely also to under represent similar categories of non-respondents.
Table 1: Characteristics of sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>GB 2001</th>
<th>ESRC 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEMOGRAPHIC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lives alone</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Female</td>
<td>57</td>
<td>53</td>
</tr>
<tr>
<td>Age 75+</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Widowed</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td><strong>MATERIAL RESOURCES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational qualifications</td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>Class 1 &amp; 2</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Car owner</td>
<td></td>
<td>58</td>
</tr>
<tr>
<td>Home owner</td>
<td>68</td>
<td>72</td>
</tr>
<tr>
<td><strong>HEALTH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longstanding illness</td>
<td>61</td>
<td>62</td>
</tr>
<tr>
<td>Problems with sight</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>Problems with hearing</td>
<td>41</td>
<td>36</td>
</tr>
<tr>
<td>Health rated good/v. good</td>
<td>71</td>
<td>73</td>
</tr>
<tr>
<td>GHQ 12 Score</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td><strong>SOCIAL CONTACT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See family weekly</td>
<td>66</td>
<td>62</td>
</tr>
<tr>
<td>Phone family weekly</td>
<td>85</td>
<td>81</td>
</tr>
<tr>
<td>See friends weekly</td>
<td>70</td>
<td>71</td>
</tr>
<tr>
<td>Phone friends weekly</td>
<td>67</td>
<td>64</td>
</tr>
<tr>
<td>See neighbours weekly</td>
<td>88</td>
<td>89</td>
</tr>
</tbody>
</table>

LONELINESS AND SOCIAL ISOLATION

**Prevalence of loneliness**

Survey data was used to estimate the prevalence of loneliness among older people in contemporary Britain and make comparisons with historical data sets collected in the middle of the last century (Sheldon1948; Townsend1957; Tunstall1966). The three-comparator studies all used similar methods. Each selected random samples of older people (aged 60 or 65 and over) (N: 261-603, response rate: 78-96%) living in the community and collected data using structured interviews. Changes in the demographic and social structure over the last 60 years are reflected in differences between the studies in the prevalence of key risk factors for loneliness such as being female and living alone. The present study has a smaller proportion of female respondents than historical studies (48% v 60%) but a higher proportion who were currently married (61% v 40%). Consistent across all four surveys is the observation that only small minorities of older people (around 6%) reported that they were ‘severely lonely’ (see Table 2). The proportion reporting that they did not feel lonely has decreased over time (79-61%) but wide confidence limits indicate the imprecision of the reported prevalence rates and therefore do not support the assertion that the prevalence of loneliness has decreased in the last 60 years.
Table 2: Prevalence of loneliness in different studies

<table>
<thead>
<tr>
<th>% Lonely</th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheldon 1945</td>
<td>8</td>
<td>13</td>
<td>79</td>
</tr>
<tr>
<td>Townsend 1958</td>
<td>5</td>
<td>22</td>
<td>73</td>
</tr>
<tr>
<td>Tunstall 1963</td>
<td>9</td>
<td>25</td>
<td>66</td>
</tr>
<tr>
<td>ESRC 2001</td>
<td>7</td>
<td>32</td>
<td>61</td>
</tr>
</tbody>
</table>

Risk factors for loneliness

‘Risk factors’ for loneliness were grouped into categories: socio-economic, health resources, material resources, social resources and social networks. The relationship between each variable and the prevalence of loneliness was tested in order to identify “peer group” patterns of loneliness. This analysis revealed that loneliness was most likely to be reported by specific groups of elders: the very old, women, the non-married, those who live alone, those lacking material resources (non home or car owners), those without educational qualifications, the physically/mentally frail and those who spent long periods of time alone. No relationship was observed with levels of contact with family, friends or neighbours.

Clearly many of these factors are inter-related. In order to eliminate the effects of confounding, a multi-factorial analysis using ordered logistic regression was undertaken. Each set of factors was entered individually into the regression model and the independence of the association with loneliness established. Factors not independently associated with our outcome variable, loneliness, were eliminated. This exercise revealed that there were both factors that increased ‘vulnerability’ to loneliness and those that had a ‘protective’ effect (see Table 3). Greater vulnerability to loneliness was associated independently with 6 characteristics: not being married (with the widowed most vulnerable), increased time spent alone, increased perception of loneliness over previous decade, poor health rating, health worse in old age than expected and mental morbidity (as measured by the General Health Questionnaire [GHQ-12] (Goldberg & Williams 1988)). Two factors were independently associated with decreased likelihood of experiencing loneliness. These were advanced age and the possession of educational qualifications.
Table 3: Risk factors for loneliness

<table>
<thead>
<tr>
<th></th>
<th>Odds ratio</th>
<th>Confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>1.49</td>
<td>0.81 – 2.75</td>
</tr>
<tr>
<td>Widowed</td>
<td>3.25</td>
<td>2.14 – 4.95</td>
</tr>
<tr>
<td>Divorced</td>
<td>1.79</td>
<td>0.99 – 3.22</td>
</tr>
<tr>
<td><strong>Health status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GHQ = 0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>GHQ score 1-3</td>
<td>1.35</td>
<td>0.96 – 1.92</td>
</tr>
<tr>
<td>GHQ 4+</td>
<td>3.25</td>
<td>2.14 – 4.95</td>
</tr>
<tr>
<td><strong>Rated health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>0.92</td>
<td>0.53 – 1.58</td>
</tr>
<tr>
<td>Good</td>
<td>0.99</td>
<td>0.57 – 1.70</td>
</tr>
<tr>
<td>Fair</td>
<td>1.07</td>
<td>0.57 – 1.97</td>
</tr>
<tr>
<td>Poor</td>
<td>1.14</td>
<td>0.51 – 2.53</td>
</tr>
<tr>
<td><strong>Health expectation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Worse</td>
<td>1.16</td>
<td>0.81 – 1.65</td>
</tr>
<tr>
<td>Same</td>
<td>1.05</td>
<td>0.67 – 1.63</td>
</tr>
<tr>
<td><strong>Social resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time alone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td>2.12</td>
<td>1.46 – 3.00</td>
</tr>
<tr>
<td>Always</td>
<td>3.22</td>
<td>1.68 – 6.23</td>
</tr>
<tr>
<td><strong>Lonely</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Same</td>
<td>0.5</td>
<td>0.31 – 0.82</td>
</tr>
<tr>
<td>More</td>
<td>3.78</td>
<td>2.18 – 6.49</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 – 74</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>75 – 84</td>
<td>0.83</td>
<td>0.60 – 1.14</td>
</tr>
<tr>
<td>85+</td>
<td>0.41</td>
<td>0.21 – 0.78</td>
</tr>
<tr>
<td><strong>Qualifications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.72</td>
<td>0.52 – 0.99</td>
</tr>
</tbody>
</table>

**THE EXPERIENCE OF LONELINESS**

**Owning up to loneliness**

Research on older people is rarely participative and therefore perhaps not surprisingly participants may present to the survey interviewer only their public accounts (Cornwell 1984). Even within qualitative research, the private account is securely hidden until the investigator is able to establish empathy and participatory relationships with participants (Bond & Corner 2001). The public account, the account that participants assume the interviewer wants to hear or which is constructed with the public accounts of others, dominates (Corner 1999). Of the 45 participants in the phase 2 qualitative follow up 7 (15%) reported being ‘always’ or ‘often lonely’ at the phase 1 follow up survey (15 were sometimes lonely and 23 were never lonely). But during the qualitative interviews 26 (58%) reported being lonely and for a further six the investigator was confident that they were not able to report their feelings of loneliness. These data suggest substantial under reporting in quantitative surveys of the experience of loneliness. This may reflect the insensitivity of our measurement tools, the social ‘undesirability’ of admitting
loneliness or a different interpretation of loneliness in the two interview situations or the
greater focus of our qualitative interviews upon the social relationships of our
respondents.

Meanings of loneliness

When asked how they would define loneliness participants in phase 2 identified three
distinct definitional categories: functional, a state of mind and family and friends network
related. Participants used these categories either singularly or in combination.
Functional loneliness was articulated in terms of the loss of a range of abilities and the
loss of practical aspects of daily life, for example a combination of loss of health with
financial loss (601:3:13)*. Loneliness as a state of mind reflected an individual’s ability
to find ways of filling time, happiness at spending time alone or the ability to motivate
oneself to do things or meet new people. For example the lady who forced herself to go
out and join a local village club (305:3:34). The size of the social network and the
closeness of others around you defined network loneliness. The presence or absence of
a confidant was identified as important. For example the loss of a life long partner was
networks of family and friends as the most important with a further 12 in combination
with one or other types.

Loneliness trajectories

Participants described loneliness as a process with temporal changes. It was something
to be experienced over a period of time; it was not a static event. Its intensity would
change over time. For a minority (3/26) loneliness had decreased across the life course.
For example, a woman who developed coping strategies and who became more
comfortable with her own company over time (106:5:6). For some (7/26) loneliness was
experienced after a specific event in time such as the loss of a partner (405:5:6). But for
the majority (15/26) the intensity of loneliness increased across the life course.
The experience of loneliness was also associated with different times of the year. For
some (9/26) the season of the year, particularly during bad weather, registered a
change in perception of loneliness, for example the woman who was concerned about
falling (202:6:41). For others it was related to a particular day of the week or date, for
example the person who found it difficult on Saturdays when most people are tied up
with their families (602:2:34) or on anniversaries (402:9:7). These seasonal and
temporal variations in the experience of loneliness were mirrored in the quantitative
survey. Of those who were often, sometimes or always lonely, 54% experienced this at
specific times, most notably in the evenings.

Influential factors

In discussions about the causation or prevention of loneliness 27 factors were
mentioned by participants that could be grouped into five categories: social network,
community, activities, functional aspects and state of mind. A sixth miscellaneous
category comprised mainly issues relating to pet ownership.

Social network factors were raised by the large majority (36/45) of participants with a
majority (29/45) talking about the benefits of having a good supportive family and a
large minority (19/45) discussing the key role of a partner. Widowhood was presented
as key reason for why some (13/45) felt lonely and like divorce is a barrier to social

* Space does not permit the full use of quotations to illustrate the data. For audit purposes the (I:J:K) refers to
(Participant number, transcript page, line number).
interaction with friends (507:4:38). Not all referred to positive aspects of family. A few (8/45) highlighted negative aspects of family relations as being influential in their loneliness, for example the desire to see more of their children or grandchildren (403:6:10). Friends were an important factor in ameliorating loneliness for a majority (26/45) of participants but the decline in the number of surviving friends with age was highlighted (603:6:39). Absence of friends was not a problem for all, for example where there was an active family network (60:6:39) but 7/45 participants talked about their lack of friends or dissatisfaction with the frequency with which they saw them (403:5:45).

Community influences reflected attitudes toward the local environment as well as participants’ sense of place or community. For about half, neighbours were an important influence. The majority of these (19/24) emphasised the role of good neighbours, for example support in time of crisis or for particular activities (204:4:43), but for some unfriendly neighbours increased the chance of loneliness (306:6:16). For some the physical environment was influential factor in their loneliness, for example the woman who felt isolated because she had limited access to shops and other facilities (301:7:1).

Keeping active was perceived as an important prevention for loneliness and an about half (22/45) commented on the need for interests and hobbies. Some of the men reflected on the different gender experience of their cohort and the challenge for men of adjusting to retirement (504:4:49) (501:4:6). Useful activities and hobbies deemed as ‘useful’ were seen as important, for example for some maintaining some kind of paid work (203:8:43) (701:2:22), participation in church activities (206:3:22) or for a number gardening (506:4:20).

For about half (21/45) health was an important factor in loneliness, for example in the way health affected their own levels of physical activity (402:6:45) (502:6:44) or of their partners (205:3:14). Giving up the car was felt to be restrictive because it reduced mobility (305:9:10) and made social interaction outside the home (702:1:41). Income was another functional influence highlighted by participants, for example by restricting social activities and travelling.

A significant number of participants (26/45) stressed the importance of the state of the mind of the individual and particularly different personalities (14/45) as being influential. For some men the response to retirement from paid work was seen as a ‘state of mind’ (501:7:5).

UNDERSTANDING LONELINESS AND ISOLATION

Loneliness and isolation are well-established concepts in the study of ageing. Our understanding of loneliness and social isolation, however, has been based on a small collection of studies undertaken over the last fifty years. Traditionally loneliness and isolation are presented as a problem of later life often associated with the quality of social relationships and the inevitable experience of loss in later life — the loss of significant others, of health, of social activity or of material resources. This study confirms these traditional presentations of loneliness and isolation but highlights their greater complexity than generally recognised. We conclude:

Despite significant changes in living arrangements and the nature of social networks over the last fifty years there is little evidence that current generations of older people are lonelier than earlier generations. However our survey data does detect a decrease in the prevalence of older people who are never lonely.

The meaning of loneliness to older people is important for understanding their response to loneliness and for the development of appropriate policy responses. Participants
highlighted three categories of loneliness: functional loss, declining or dysfunctional social networks and state of mind.

The experience of loneliness changes over the life course. Three trajectories are highlighted: regenerative, degenerative or existential trajectories.

Two mechanisms are hypothesised: acute or sudden changes in life circumstances leading to a sudden onset of loneliness and chronic onset stemming from the gradual build-up of losses over time.

Risk factors for loneliness or isolation are complex and should take account of different meanings to participants.

Risk factors may be increase vulnerability to loneliness or have a protective effect. In our multivariate model not being married, a perception that they are increasingly lonely, a poor health rating, poorer health than expected and psychiatric morbidity were associated with vulnerability. Advanced age and educational qualifications were protective.

Policies developed to alleviate loneliness should focus on the complex combination of factors that influence quality of life rather than respond to individual risk factors.

Future surveys need to include more sophisticated methods for ‘measuring’ loneliness and isolation, which take account of the public voice of participants and the different meanings they give to the term loneliness.

Activities

Members of the project team have been active participants within the Growing Older Programme including the presentation of interim findings at the 2001 Annual Conference of the British Society of Gerontology, the spring 2002 meeting of the British Geriatrics Society, the 2002 World Congress of Gerontology, the 2001 conference of the European Medical Sociology group and the annual conference Medical Sociology Group of the British Sociological Association, the 2002 XV World Congress of Sociology and the 2002 Annual Meeting of the Gerontological Society of America. The research team is developing an accessible summary of the study for the lay public and has proposed the production of a specialist text on the nature and consequences of loneliness in later life, as well as publications in peer reviewed journals.

Outputs

PUBLISHED ARTICLES


SUBMITTED FOR PUBLICATION AND UNDER REVIEW

IN PREPARATION


PRESENTATIONS


Impacts
As dissemination has only just started there are none to report.

Future research priorities

Surveys of loneliness describing prevalence and risk factors in younger and middle-aged adults.

Longitudinal studies to examine factors influencing changing experiences of loneliness.

Methods to evaluate health promotion activities to prevent loneliness.

Evaluations of interventions to prevent loneliness.

References

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