Safeguarding the Convoy

A call to action from the Campaign to End Loneliness

Oxfordshire age UK



Campaign to End Loneliness
CONNECTIONS IN OLDER AGE

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The Campaign to End Loneliness is a project which aims to create connections in older age. It was started in 2010 by four founder partners, Age UK Oxfordshire, Counsel and Care, Independent Age and WRVS, and is funded by the Calouste Gulbenkian Foundation. Before March 2012 we will achieve the following objectives:

- We will raise awareness of the problems caused by loneliness and why they matter
- We will identify and raise awareness of what works in reducing loneliness in older age and where the gaps are for interventions to succeed
- With others, we will create a vision of a society where loneliness in older age is ended
- We will identify what we all can do to future-proof our lives against loneliness.

Age UK Oxfordshire thanks the Calouste Gulbenkian Foundation for its generous support.

We also wish warmly to thank Susan Davidson, Phil Rossall, Gill Rowley and Harry Ward for their help in preparing the publication, and Stephen Burke for his inspiration and vision in helping to build the Campaign.

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Age UK Oxfordshire is an independent local charity, working to ensure that people grow older in comfort, with support where they need it, and with chances to have a life worth living.

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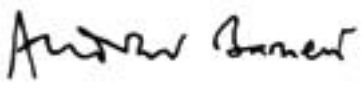
Giving meaning to day-to-day experience

Companionship is important throughout our lives; mutual support and the sense of purpose we feel through our relationships help to give form and meaning to our day-to-day experience. Loneliness is, of course, a human condition which affects all ages but older people are particularly vulnerable to becoming isolated, through loss of friends and family, loss of mobility or loss of income, and that all too often leads to loneliness. In a rapidly ageing society we need to consider very seriously not just the practical but the emotional and psychological implications of the growing numbers of older people within our communities.

In 2008, the Calouste Gulbenkian Foundation identified demographic ageing as an important area for intervention and began an exploratory phase, commissioning papers and hosting investigative seminars, to identify where we might best focus our activities. Isolation and loneliness in older age were soon highlighted as an issue of increasing concern and, with our interest in protecting and building connections between individuals to create more resilient communities, we decided to support initiatives in this area. It was at one of these events that the idea of forming a coalition of organisations to tackle loneliness in older age was first suggested. While it was acknowledged that there are many excellent activities that seek to address the causes of isolation already taking place across the country, it was felt that a more concerted and co-ordinated effort was needed to tackle the extent of this major problem. Following a number of discussions and activities to further the idea, we supported a symposium to assemble existing evidence on isolation and loneliness, to gain an understanding of priority groups, and to explore the role and ambition of the proposed campaign. We confirmed our support for the campaign in June 2010.

This ambitious initiative will also inform the Foundation's wider body of work on ageing, which aims to create age-inclusive ways of responding to demographic change by supporting more meaningful connections – both for older people and, crucially, across generations too. With a history of funding cross-cutting and transnational work, we will look to share valuable cross-disciplinary learning on how the civil, public and private sector can help people to maintain relationships, and on how to enable individuals to plan for the future. We are in a privileged position to work with a wide range of professionals – frontline service providers, civil society leaders, social entrepreneurs, designers, and academic researchers among others – and our aim is to create a coherent picture of the measures we all need to take to ensure that our society is one where it is a pleasure to grow old and which values people of all ages.

By launching this call to action and inviting organisations to collaborate, the Campaign to End Loneliness will create a much-needed consensus on this debilitating social issue, adding considerably to the way in which we think as a society about demographic change – to go beyond thinking solely about the fiscal impact, and instead to consider the emotional and personal impact this demographic shift could mean for all of us. We are delighted to be a part of this exciting initiative and look forward to working with the Campaign partners to end loneliness in older age for good.



Director, Calouste Gulbenkian Foundation, UK


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The Campaign to End Loneliness

The Campaign to End Loneliness has been launched by five organisations drawn together by a shared impulse to tackle a major social ill.

The Campaign aims to create connections in older age. Led by Age UK Oxfordshire, Counsel and Care, Independent Age and WRVS, it is funded by the Calouste Gulbenkian Foundation.

The initiative springs from a recognition of the horror of loneliness and its pernicious impact on the older people with and for whom we work. It is driven by a determination to tackle the problem more thoroughly than before, and more effectively, by working in partnership with others for the long term.

The founder partners of the Campaign have been guided by leading researchers in studying the problem, its causes and contributors. We have begun the job of collating evidence for what seems to reduce loneliness and this document contains the results of this early work.

We have also scanned the field of endeavour – the many agencies across society which directly or indirectly work to connect people with one another – and found a rich tapestry of helpful schemes, initiatives, services and policies. Some of the agencies that provide them have already contributed to our initial research symposium in 2010, and we thank them for their contribution. We look forward to receiving further ideas and action in the future. To end loneliness in later life is a major objective, and there is much more that could be done.

We have continued to listen to older people themselves. We have heard of the debilitating effect of loneliness, the waste of potential among so many who want to contribute but find themselves cut adrift, and of the need for more to support individuals in avoiding or overcoming loneliness.

As our work continues over the coming years we hope that others will join us in our commitment to end loneliness. We start our Campaign in full understanding of the ambitious nature of the proposition under which we campaign, and with every determination to achieve it.

If you share our desire to tackle this terrible societal ill and defeat it, and a willingness to take action to make that happen, please join us. We hope you will play your part in this concerted response to loneliness in older age, and do what you can to secure a future free from loneliness – for yourself and for others. This publication establishes the base from which we will act against loneliness in the coming years. It offers a challenge to all to take part in this endeavour.

How you can take action

Individuals

1 Are you young, and think older age does not affect you? **Helping in your neighbourhood** can be two-way. Get to know your older neighbours, and offer help for the things you find easy; they will impress you with the offers of help they can give in return.

2 Are you approaching older age? **Cherish your connections after retirement:** this is a time when your social circles change and it takes effort to stay in touch

3 Are you in retirement? **Keep contributing** – get involved in your local community as a volunteer.

4 Tell us what you are doing or will do to end loneliness by making a pledge at our website: visit www.campaigntoendloneliness.org.uk

Voluntary and community sector

1 Are you already working to prevent loneliness? Tell us about it so we can publicise your work and raise the profile of the need to end loneliness among others: again, visit our website.

2 Become a partner of the Campaign to End Loneliness by promoting your work, or by working more closely with us.

National government

1 Do you make policy? How will it help older people to stay connected and contributing?

2 Are you working on well-being? Make sure loneliness is measured.

Local government

1 Are you reconfiguring services? What is the impact on loneliness? Can you create services which make connections instead of breaking them?

2 Are you building your community? Can you make your area a great place to grow old in?

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The challenge

'Loneliness and the feeling of being unwanted is the most terrible poverty.'

Mother Teresa

Ending loneliness

That unhappy feeling of a gap in your life – between the human bonds you crave and those you actually experience – is common and often deep. Loneliness is a social ill, a modern 'giant' at least as malign in its effects as the five abstract giants (ignorance, idleness, want, disease, squalor) confronted by Beveridge in the 1940s. It blights the lives of about 1 in 10 older people, and it weakens society.

We must take action to prevent and to cure this great ill. It is time to treat loneliness with as much seriousness as we do other great challenges to health, such as cancer, and work to end it with the same drive.

This publication draws together the expertise of the leading researchers in the field, to set out clearly the extent of loneliness, and what can be done to tackle it. It also echoes some of the voices we have heard as we have talked to older people, to providers and to public bodies about what loneliness is, how it feels and how we can end it. Some of these are quoted in the text.

Loneliness has long been recognised as a problem, spurring action at every level, from the concerned neighbour knocking on a door to major national initiatives. Now is the time to draw these efforts together. We must have a clearly defined cause, an evidence-based approach, and relentless determination in our joint action.

In this commentary we offer a call to action from the Campaign, written by a founder partner, Age UK Oxfordshire. We will draw on the work of the researchers published in the section beyond this commentary. We invite you to examine the research in the areas of most relevance to you; there is much we can share and learn to improve our chances of ending loneliness in older age.

What is loneliness?

'The days are very long when the walls are the same.'

Help the Aged research

Loneliness is a psychological state, an emotional response to a perceived gap between the amount of personal contact an individual wants and the amount they have. It is clearly linked to, but distinct from, the objective state of social isolation.

There are different types of loneliness, such as social loneliness and emotional loneliness. As Vanessa Burholt explains:

'Emotional loneliness is the absence of a significant other with whom a close emotional attachment is formed (e.g. a partner or best friend) and social loneliness is the absence of a social network consisting of a wide or broad group of friends, neighbours and colleagues.'

'When friendship disappears, then there is a space left open to that awful loneliness of the outside world which is like the cold space between the planets. It is an air in which men perish utterly.'

Hilaire Belloc

Men and women tend to experience loneliness differently. Men are less likely to experience social loneliness than women, who may have more developed social networks (and therefore experience a greater sense of loss when these are broken down). Male dependency on a single key relationship is all the greater as a result. For men, the impact of bereavement can be devastating and a cause of deep depression.

Depression affects 22% of men and 28% of women aged 65 or over.

Health Survey for England 2005: health of older people, IC NHS, 2007

'I've gone three years without talking to hardly anyone.'

Cattan for Help the Aged, 2002

As Burholt explains, based on her studies of rural areas: 'For both men and women, living alone and poor mental health were strongly associated with increased loneliness. However, whereas for women loneliness was predicted by population density (i.e. increases in sparsity are related to increases in loneliness), and physical health (poor health is associated with greater levels of loneliness), neither of these factors predicted loneliness for men.'

'I get lonely. You can't help it. The worst day is Sunday – that's my worst day. I don't know why, because every day is the same when you're at home all day.'

Cattan for Help the Aged, 2002

Loneliness can take different forms. It can be a chronic condition which is exacerbated with advancing age, or a condition which flares up in response to life events. As Jenny de Jong Gierveld observes, loneliness can be short-term or 'long- term, sometimes hopeless'.

These different forms of loneliness require different responses, in both prevention and cure.

Loneliness is bad for your health. The World Health Organization (WHO) rates loneliness as a higher risk than lifelong smoking. Researchers also link lack of social interaction with the onset of degenerative diseases such as Alzheimer's: an illness which costs the UK an estimated £20 billion a year and has an even higher human cost. One study reported a doubled risk of Alzheimer's disease in lonely people compared with those who were not lonely.

It has been shown that loneliness makes it harder to regulate behaviour, rendering people more likely to drink excessively, have unhealthier diets or take less exercise. There is also evidence that loneliness adversely affects the immune and cardiovascular systems.

Loneliness is closely associated with depression, which the WHO has identified as the foremost disability. Rates of depression rise with age, from 25 per cent of older people living in the community to 40 per cent at age 85 and beyond.

Unsurprisingly, such problems increase in institutional settings. Some 40 per cent of older people have consulted their GP about a mental health problem; this rate rises to 50 per cent for those in hospital, and 60 per cent for those in care homes (Department

of Health, 2010). A meta-analysis found that diagnosis of depression for those aged over 65 increased the mortality rate by 70 per cent.

Loneliness and poor physical health also interact. In some cases a health condition may trigger greater isolation and loneliness. For example, hearing impairment has been found to increase loneliness and is likely further to erode personal resilience. Decreasing mobility, and aches and pains that become part of life, also inhibit people's ability to keep up with their family and friends.

Loneliness increases as people become less able to undertake the activities of daily living. Indeed, such physical limitation is the largest single predictor of loneliness.

It is vital that health professionals are alert to the two-way links between poor health and loneliness and are able to make connections in diagnosis and treatment.

How lonely are we?

Christina Victor shows that research over decades has found a fairly constant proportion (6–13 per cent) of older people who feel lonely often or always. As populations age, this means ever more individuals.

'An epidemic of loneliness, insidiously affecting those among us who have seen the ebb and flow of countless seasons, seen the world grow smaller and then grow too large again.'

Dr Ishani Kar-Purkayastha MRCP,
***The Lancet*, Vol 376, Issue 9758**

Recent estimates place the number of people aged over 65 who are often or always lonely at over 1 million (Age Concern and Help the Aged, 2009). In 2006 a Help the Aged survey found that half a million older people had spent Christmas Day alone (ICM Research for Help the Aged, 2007).

The population that is isolated and at risk of loneliness is much larger. Recent studies show that:

- 12 per cent of older people feel trapped in their own home (GfK/NOP, 2006)
- 6 per cent of older people leave their house once a week or less (Age Concern and Help the Aged, 2009)
- nearly 200,000 older people in the UK have no help to get out of their house or flat (ONS, 2010)
- 17 per cent of older people are in contact with family, friends and neighbours less than once a week, and 11 per cent are in contact less than once a month (Victor et al, 2003)
- over half (51 per cent) of all people aged 75 and over live alone (ONW, 2010)
- 36 per cent of people in the UK aged 65 and over feel out of touch with the pace of modern life and 9 per cent say they feel cut off from society (GfK/NOP, 2005)
- half of all older people (about 5 million) say that the television is their main form of company (ICM, 2009).

Why are we lonely?

Loneliness is individual but also societal. Increased longevity is leading to more people living alone for longer. Families are increasingly dispersed as children move away at greater distances from their parents. Mobility within and between nations is changing the nature of communities. Society is being atomised and communities are becoming less cohesive. Inequality, which is relatively high in the UK, fosters resentment. The rapid pace of change in communications technology has left many behind.

We can be lonely at any age. But older people are especially vulnerable as a number of particular risks occur, such as negotiating the transitions that come with later life.

'People falling off their logs around me all the time. . .'

Age UK Oxfordshire interview

Transitions can trigger disadvantage. Hazardous transitions in later life include:

- retirement
- finding new ways to contribute after stopping work
- deciding where to live
- becoming a carer
- developing care needs
- being bereaved
- journey towards death.

Too often transitions mean a loss of social and emotional connections, and lowered resilience. Despite much policy debate and many special projects we are still poorly supported as we navigate some key transitions.

As well as transitions, several continuing states increase loneliness. These boil down to exclusion from resources – material, social, environmental or civic –that support people and multiply their opportunities. In communities where resources are limited there is more risk of feeling cut off and estranged. 'Social exclusion' denotes a grim reality for many, memorably conveyed by Polly Toynbee in her book *Hard Work* as 'a large No-Entry sign on the face of every ordinary pleasure'.

'Quality of life for me ends at 6 pm.'

Scharf et al for Help the Aged, 2002

1.8 million pensioners (16%)live below the poverty line (a weekly income of £119 for single pensioners and £206 for a couple).

Households Below Average Income 2008/9, chapters 2 and 6, DWP, 2010 (figures quoted after housing costs)

Older people can be vulnerable because they have fewer remedies available. Lower income and mobility, coupled with fewer social opportunities, limit the ability to cope with social loss. And there is a continuing climate of ageism which segregates older people. Too often this is because we stop making demands upon ourselves as we grow older. Our natural instinct is to contribute – living is about giving – yet this human need to be needed is denied, either deliberately or inadvertently.

'There are probably thousands like her. Men and women who have lived a lot and loved a lot. Men and women who are not yet done with being ferocious and bright but for whom time now stands empty as they wait in homes full of silence; their only misunderstanding to have lived to an age when they are no longer coveted by a society addicted to youth.'

Dr Ishani Kar-Purkayastha MRCP
***The Lancet*, Vol 376, Issue 9758**

For many, this loss of social value is the worst loss as we grow older.

Who is lonely?

Loneliness can affect anyone. Some are more at risk: the oldest old, those on low income, or in poor physical or mental health, or living alone or in isolated rural areas or deprived urban communities.

About 3.7 million older people live alone.

General Lifestyle Survey 2008, ONS, 2010 (table 3.3) and ONS mid-2008 Population Estimates (2008). Older people = age 65+

According to the 2001 Census, over 1.5 million people aged 60–74 were living in rural England, and 0.8 million aged 75+.

Sheer physical distance creates loneliness. As noted by Vanessa Burholt, extreme rurality is a risk factor, particularly for women. But the highest levels have been found in the urban socially deprived.

Eight per cent of people aged 60+ in England and Wales say they live in fear of crime.

Opportunity for All, DWP, 2007

As Thomas Scharf shows, older people can become lonely despite the population density of urban areas, as they become unable to maintain social connections. He suggests three key factors: the increasing tendency to design cities around the needs of younger people; high population turnover in cities, making it difficult to keep longstanding connections; and social issues affecting urban areas such as crime and anti-social behaviour, which conspire to alienate older people. We also see an association between certain ethnic minority groups and heightened levels of loneliness, but this is an area which clearly demands more research.

'We have a lovely park nearby which I used to love to visit. But when I last visited there was a large group of boys and girls fighting and swearing so now I am too frightened to go back.'

Scharf et al for Help the Aged, 2002

And yet, community type alone is not a predictor. There are variations in levels between similar communities. Certain neighbourhoods are higher-risk but communities can act to protect themselves.

'Since they have remodelled the place, I'm very happy with it. The place is clean now.'

Scharf et al for Help the Aged, 2002

Successive waves of the English Longitudinal Study on Ageing point to increasing risks and also links:

- a clear and significant correlation between low socio-economic status and loneliness
- having children but not feeling close to them brings greater loneliness than being childless
- contact with children is an especially effective antidote: this applies to cross-generational contacts in general, i.e. contact with children and young people as well as with one's own offspring
- having friends is more important in warding off loneliness than frequent contact with them
- loneliness increases as amenities decrease.

How can we end loneliness?

Jenny de Jong Gierveld points out that a significant part of our **personal** approach must lie in working out how to manage our own expectations and adapt to transitions. For **wider society** the challenge is to support the maintenance, and where necessary replacement, of social connections as we age.

This means breaking down the barriers that get in the way of our relationships in later life – from sheer distance or physical constraints to impediments such as the fear of crime or high cost. It also means enabling new forms of relationship – by demystifying

the internet, or utilising the telephone. And it means supporting the constant renewal and refreshing of relationships – through the creation of opportunities for all forms of social interaction. The opportunities we currently have for 'a chat and a cuppa' are precious. Wherever they arise we should be protecting and extending these routine and inexpensive ways of keeping people connected. But we urgently need to add to the repertoire, to the other ways humans engage with one another, such as through work, mutual support and contribution.

Older people face a number of barriers to their continued participation in the wider community and to their relationships. Many things separate us, but death is the only barrier that cannot be overcome. Distance requires affordable and appropriate transport. Physical disability must be overcome with effective support. Age barriers need to be removed. Fear of crime should be met with protection and reassurance. Financial impediments must be surmounted through action on price or income. Breaking down these barriers to relationships is surely our first priority. Far better to prevent than to cure.

But loneliness is unfortunately already a reality for many. Relationships cannot always be maintained. So we also need restorative action, to reach those living with or on the brink of loneliness.

'When I feel lonely I go out to make myself better. I go in the car and sit in the supermarket car park where there are lots of people about and lots of traffic and that helps.'

Cattan for Help the Aged, 2002

Fortunately, several different kinds of service already exist to do this. They fall into three main groups:

- one-to-one services
- group support services
- services supporting or enabling community participation.

Most **one-to-one services** to combat loneliness fall under the broad heading of 'befriending'. Most of these operate along similar lines, by putting a vulnerable older person in regular contact with a volunteer befriender. Services can be delivered in person, over the telephone or over the internet. Befriending services are usually provided by local voluntary organisations, and often link particularly with older people in contact with health or social care services. For example, Age Concern Lewisham provides a befriending scheme to support older people when they leave hospital, following incidents such as a fall, as part of an 'intermediate care' approach. Such services are very highly valued by the older people that receive them, and reportedly bring benefits to the volunteers who participate in them too. Unfortunately, however, these schemes have not been the subject of extensive evaluation, so the evidence of their effectiveness is far from robust. None the less, what evidence does exist (see Mima Cattan's chapter) shows cause for optimism about these schemes and suggests further work should be done to determine the optimal model of befriending.

Group services fall into one of two main categories: day centre-type services – including lunch clubs, drop-ins, community cafés etc. – and social group schemes, which aim to help people to widen their social circles. Given the importance of social networks, there is good reason to believe that bringing people together in groups to share an experience should be effective in combating loneliness and the research that does exist – much of which is qualitative – suggests that older people and their carers value such schemes. A cautionary note suggests that in some cases loneliness may be contagious, and that group schemes may be ill-suited to the needs of some – such as bereaved men. Clearly, therefore, we need to

gather more evidence on how best to develop group interventions.

'Lonely people, in talking to each other, can make each other lonelier.'

Lillian Hellman

The final form of loneliness support comes from those schemes that support older people to engage in activities within the **wider community**. Several programmes operate to increase participation in existing activities such as sport, and use of facilities such as libraries and museums, including, for example, reminiscence projects and intergenerational and family history work, as well as outreach programmes from art galleries and music organisations. There are also programmes that encourage older people to take part in learning and information technology such as Age UK's and Age Concern's Silver Surfers and 'ITea and biscuits', and NIACE's work on older learners. The timebank scheme also helps older people to stay involved with their communities, by facilitating the trading of a contribution from them in return for support from others. A qualitative survey found that one timebank, established by the Rushey Green Practice in Catford, had given members someone to talk to and also got them out of the house. The scheme improved their social networks and enabled people to gain support and learn from each other's experience, either through meeting informally or through telephone helplines. Mixing people up also helped increase people's understanding and tolerance of conditions such as depression and other mental problems.

'That little bit of help.'

These schemes look promising, and may both prevent and cure. Again, they have not always been robustly reviewed for their impact and therefore determining which schemes work best is not yet possible.

But as Mima Cattan says, we will always need a multi-pronged approach – generic solutions will not work. We must offer multiple routes out of loneliness. Targeting and tailoring are key. She also warns against complacency: 'It is frequently assumed that if people participate in an activity it is acceptable and attractive to them. However, some older people will make do with activities and services that do not meet their social activity or social support needs, simply because there are no other options.' Services which may be lifelines for some can present a depressing prospect for others.

The Campaign to End Loneliness wants to ensure that services to combat loneliness are based on the best evidence as to what works – recognising the different forms, the different triggers and, perhaps most importantly, the different individuals who experience it. But two things are already very clear:

- If schemes to target loneliness in older people are to be effective, they must involve older people at every stage, including planning, development, delivery and assessment. Often the vital step of asking what people want is missed out when designing services.
- In the current climate of cuts, it is important to emphasise that the loss of a service which has had success at alleviating loneliness is felt as worse than never having had the service at all.

Who is responsible for ending loneliness?

Emotional states cannot be altered by law. You cannot befriend by diktat. There are no Departments of Loneliness, nor should there be. However, loneliness is not a purely private matter. A problem which is often about a lack of connections needs a connected response. We should all play our part.

Just as we understand that beating cancer is not about legislating against the problem,

or solely about individual actions, so too we must take action at a number of levels in order to tackle loneliness. As with cancer, individuals must take the best advice as to how to secure a future that is loneliness-free; sensitive and effective services must be provided to aid those who would otherwise succumb; and governments – both local and national – should work to put in place conditions in which prevention is easy, and succumbing to it is not inevitable, even when things go wrong.

In early discussions of the Campaign to End Loneliness, Jenny de Jong Gierveld introduced us to the concept of one's personal 'convoy': the assembling of family, friends, social contacts, work, passions and pastimes, resources and assets which you take forward through life, and which secures your confidence and enables you to lead the life you choose to the full. This convoy travels with us through our lives, but is prey to assaults and losses along the way, especially in later life.

'I have to act to prevent the gradual shrinkage of life.'

Age UK Oxfordshire interview

The priority for combating loneliness is for **everyone in society to be safeguarding the convoy.** Authorities and services can support and bolster, individuals can build and shore up through our lives. Ending loneliness requires mutual responses: responsibility shared whether we are simply acting as individuals, or as part of the wider civil society, or are in authority at a national or local level.

Government cannot banish loneliness. But any government intent on making societybigger must help bring out of the shadows those who feel cut off.

Central government's role lies in enabling 'life as usual' with all its everyday social connections, and in breaking down the barriers: overcoming poverty, fear of crime, lack of transport, poor health, age discrimination.

Hence, the government's stated aim of recent years to target loneliness is welcome. In December 2007, the concordat for social care Putting People First declared 'the alleviation of loneliness and isolation' to be 'a major priority'.The landmark publication *A Sure Start to Later Life: ending inequalities for older people* (January 2006) argued that 'isolation, loneliness and poor social relations are also major factors leading to the exclusion

Sharing responsibility for loneliness

The local state (councils, health services) Pavements are repaired; transport works; older people are involved

The national state (government departments for pensions, health, housing, communities) Incomes are adequate, ageism is tackled, loneliness is targeted and measured

Voluntary and community sector (community organisations, charities etc.) Ending loneliness is an explicit goal, mutual support is enabled, impacts are measured

Individuals Phones are answered, coffee is made, connections are cherished

of older people. Social isolation affects about one million older people, and has a severe impact on people's quality of life in older age. Tackling social isolation and loneliness is ... vital if we are to end social exclusion.'

It is not yet clear how far these bold plans of a previous government will be taken forward, although it is encouraging to note the emphasis placed by the current government on well-being. Any government serious about enabling well-being must acknowledge the problem of loneliness as one of the targets of its activities. As measures of happiness and well-being are developed, they should use what is known about measuring loneliness, reducing it as well-being increases.

Welcome too is the theme of improving community connections. The current Government's determination to create – or at least enable – a 'big society' presents a real opportunity to highlight loneliness. We believe the 'Big Society' is an invitation to us all to live out the full potential of ordinary people, communities and their clusters to take the lead in living, working and supporting each other, together.

The Big Society must be a society for all ages, with all invited. National government holds levers that enable or inhibit the inclusion of older people. Its actions will swell or, we hope, reduce the ranks of lonely older people.

'All my life I've been needed one way or another – as journalist, wife, mother – and we all need to be needed.'

***My Home Life*, Help the Aged, 2008**

One driver of loneliness is pervasive ageism. Such attitudes underlie events which push people into loneliness. Direct discrimination forces them out of work or a volunteer position. Subtle, sometimes well-meant, ageist attitudes mean that people cease to be involved, are no longer asked for their views, or their help, and find themselves without a role in the family or the community to which they once belonged. Legislation to end age discrimination, and the subsequent promotion of more positive attitudes to older people's equality and human rights, must therefore be part of any strategy to address loneliness in later life.

76% of older people believe the country fails to make good use of the skills and talents of older people.

One Voice: shaping our ageing society, Age Concern and Help the Aged, 2009

But the Government's responsibility goes beyond improving attitudes. It also holds some practical tools we need to stay connected and take up new opportunities. Several key policy areas must be approached with this in mind:

- To reduce the risk posed by lower income, **improving pensioner incomes** must remain a priority: People will inevitably experience a drop in income in later life, but we must ensure that older people have enough money not only to survive, but also to love and live. Many do not claim the benefits to which they are entitled, and it is the socially isolated who are most likely to miss out. Changes to future pensions must address the need for people to have enough money to keep up their connections

Between £3.2 and £5.4 billion of means-tested benefits that should rightfully go to older people in GB went unclaimed in 2008–9.

Income-related Benefits: estimates of take-up in 2008/9, DWP, 2010

- Housing policy must meet the need for a lifetime of maintaining meaningful social connections: housing adaptation must be available to help us to stay

independent; and advice and support services must help us make housing decisions to support this. We must look out for the impact of moving home and changing neighbourhoods on the ability to stay connected.

'Only when the worlds of architecture, design, planning and housing have understood and embraced the concept of positive ageing are we likely to see the creation of truly age-inclusive homes and neighbourhoods.'

Sue Adams in *Unequal Ageing*, Policy Press, 2009

- **Health and social care** should understand the clear impacts of loneliness on health, as noted above. They should support independence: while locally delivered, care policy is nationally framed. The welcome recent emphasis on early intervention and maintaining independence needs action: people given more choice and autonomy to access services which help them live the life they choose. Public health must encompass podiatry and older people's mental health, as well as the more headline-grabbing issues of obesity and smoking.
- Our **digital future** is for all ages and all citizens should feel part of the digital age: technology can enable older people to stay connected and be more empowered.

Only 40% of people aged 65 and over have ever used the internet.

Internet Access 2010: households and individuals, August 2010

- **Transitions, transitions, transitions** Often we connect with central government services at points of transition – but too often we merely report or record the retirement, loss of driving licence, or bereavement without taking any further account of these warning signs of future loneliness. Government must seize these opportunities to find and support people undergoing risky life transitions to ensure that loneliness is not the inevitable consequence.

Local authorities also have a vital role: it is increasingly they – councils, PCTs, police authorities etc. – that will shape what our neighbourhoods are like to age in. And as Thomas Scharf's work shows, what your neighbourhood is like matters: some protect us from loneliness, others exacerbate it. Some communities are taking great strides – such as in Manchester where the local authority, under its Valuing Older People initiative, is leading a concerted and evidently well-received effort to make the city 'a great place to grow old'. More needs to be done across the whole country.

The work undertaken as part of the World Health Organization's Age-friendly Cities programme, and picked up in the DCLG publication *Lifetime Homes, Lifetime Neighbourhoods*, pointed the way to the small changes which are needed to ensure our communities are fit for an ageing society – pavements repaired, public toilets open, transport linked, crime and anti-social behaviour tackled. Essentially, barriers to getting on with life need to be broken down in order for loneliness in older age to be ended.

In England, 10% of those aged 75+ say they have very difficult access to a corner shop; 10% have very difficult access to a supermarket; 10% to a post office; 9% to a doctor's surgery; and 16% to a local hospital.

Housing in England 2007–8: a report based on the 2007/8 Survey of English Housing, Department for Communities and Local Government, 2009

Also within local authorities' remit are many of the facilities in which older people's lives, and particularly social lives, are played out. In times of austerity it is important to recognise the role of leisure facilities, libraries and public spaces in supporting social connections, and alleviating loneliness. Too often these are seen as 'nice to have', whereas for many older people they are a lifeline.

'We do not cease to play because we grow old; we grow old because we cease to play.'

George Bernard Shaw

These services make up the fabric of our communities and are the difference between continuing to enjoy meaningful connections in life or not. But also important are the initiatives taken to foster a sense of community – services that often come under the banner of 'community cohesion' or 'community engagement' and range from Good Neighbour schemes, as in Oxfordshire and many other places, to Homeshare, timebanking, older people's forums, and other forms of civic participation.

Local authorities also have a key role to play in addressing the mental and physical health issues which so often go along with loneliness – often in a chicken-and-egg relationship. Given the clear links between poor health and loneliness it is crucial that service design delivers in a local context.

Over three-quarters of a million people aged 65+ need specially adapted accommodation because of a medical condition or disability and 145,000 of them report living in homes that do not meet their needs.

Internet Access 2010: households and individuals, August 2010

This underlines the importance of prevention and early intervention, delivering flexibility in services, and making a reality of personalisation. The simple truth is that if people are too ill to get out and about, are hampered by communication problems, or too depressed to engage, loneliness will follow. Early prevention of loneliness is crucial to prevent health threats from escalating.

Health and social care providers should directly **target loneliness** as a damaging social ailment within our communities. Many do. Befriending schemes and other loneliness prevention and cure services provided by local voluntary organisations are often funded with money from PCTs and social services departments. This should continue – with loneliness prevention and cure treated as a priority.

The voluntary and community sector must remain at the heart of society's efforts. While befriending services, lunch clubs and day centres are the most common examples of loneliness initiatives in the community, more and more other services have developed, such as e-inclusion programmes, gardening clubs, reminiscence projects and theatre societies, which are just as vital to the cause.

The voluntary sector's responsibility, therefore, is to publicise, maintain, improve and build on these services for the long term. As discussed earlier, the very worst thing that can happen to a service that is effective in tackling loneliness is that it be withdrawn from those who rely on it. So it is vital to evaluate what difference these services make and to bolster them with evidence of their impacts.

But the voluntary sector's role is not limited to the provision of direct 'anti-loneliness' programmes – it also gives people the tools to keep up life as usual for themselves. The myriad helplines and information services, transport schemes and initiatives providing 'that bit of help' daily help people maintain their own connections.

The voluntary sector also provides a place for many older people to find new ways to

contribute and stay involved when paid work ends. The army of older volunteers that sustains many local community organisations not only provides a service, but also meets the need we all have to be needed.

People aged 65+ say that the top benefits of volunteering are 'meeting people and making friends' (91%), 'gets me out of myself' (82%), 'makes me feel needed' (76%), and 'gives me more confidence' (68%).

Helping Out: national survey of volunteering and charitable giving. Low, N, Butt, S, Ellis Paine, A, Davis Smith, J, Cabinet Office, 2007

The third sector's other key contribution lies in its ability to inform and campaign – raising awareness and pressing for change. No great societal illness can be tackled without its name being known. Voluntary and community organisations must therefore continue to speak out against injustices that imprison older people in loneliness, and to prick our consciences to make us act.

'Forget sex or politics or religion – loneliness is the subject that clears out a room.'

Douglas Coupland

The organisational input into tackling loneliness is considerable, and thankfully we are no longer on the starting line. Much is being done. However, few organisations have yet recognised loneliness as the explicit target of their endeavours. Loneliness alleviation is seen as part of a broader 'take' on social inclusion, community cohesion, or even public health. And while many projects have admirable impact, the failure to acknowledge loneliness alleviation as an end in itself is instructive. Perhaps the fact that it is seen as an 'also ran' in terms of project impact is the reason why so little research has been done on its impact.

However, loneliness is not only an institutional issue. **It is for all of us to act** as individuals and members of communities, which either include or exclude.

Too often. older people find that their age comes to define them. Their various identities, as parents, grandparents, carers, workers, volunteers, community leaders, start to fall away, or be taken away. Apparently benevolent attempts to limit the burdens on older people leave them feeling they no longer have a role, limit their social connections and push them into isolation and loneliness. Ageist assumptions often underlie these actions. Sometimes we are our own worst enemy.

2.8 million people aged 50 and over provide unpaid care and 5% of people aged 85+ provide unpaid care.

Focus on Older People, ONS, 2004

We need an atmosphere of mutual support, allowing and enabling older people to continue to contribute to our families and communities. Initiatives celebrating older carers, community leaders and grandparents reinforce the message that living is about giving. We can act to offer new opportunities when relationships end – such as when carers are bereaved, or children move away. Intergenerational relationships protect against loneliness. So we must emphasise the links between children and older people in our community centres and schools.

'You don't need a CRB check to be a good neighbour.'

Age UK Oxfordshire interview

'I know people contribute a lot toward making your life but I do think you've got to try and make a life for yourself as well. I mean, I for one would not sit here for three weeks on my own with no one to talk to. I've got a free bus pass and I would go to ... one of the big places 'cause there is always somebody that will talk to you.'

Scharf for Help the Aged, 2002

Our responsibilities are not only towards a lonely 'other' but also to our future selves. We can take responsibility for our own 'convoy' of connections and take steps to secure our own personal protection against future loneliness. We can start by making choices, particularly about where we live and what we do in later life, being mindful of their impact on our future connections.

'To hell with retirement – let them advance.'

Adrian Mitchell, 'Old Age Report'

While many spend their lives longing for their retirement, too often this brings a sudden loss of social interaction and this can be the start of loneliness – particularly for men. We should think hard about our retirement decisions and how we will sustain our need to interact and contribute.

We should balance the dream of a later life in the countryside or by the sea with consideration as to how we will stay socially in touch. We are responsible for our own personal resilience and know best our own limits – while some of us forge new connections easily, others do not.

Taking responsibility for ending loneliness might be knocking on a neighbour's door,



www.istockphoto.com

or stopping for a cup of tea. It might also be about asking for help, offering a job, or about taking a decision about what job we do, until when or where we live, and who we live with. At the heart of our Campaign is the belief that people should go on contributing to the day they die. We make a huge mistake when we disable people by doing things to them. People remain people. They want to give of themselves.

'Granny, are you doing enough for other people?'

Yasmin Ball

As we take up our individual role in ending loneliness we will need to draw on support and advice that are tailored to meet this need. Ensuring this is available will be a specific focus for the Campaign to End Loneliness as it progresses.

What should we do now?

'What should young people do with their lives today? Many things, obviously. But the most daring thing is to create stable communities in which the terrible disease of loneliness can be cured.'

Kurt Vonnegut

The Campaign will pinpoint the contributions needed by all of us because this is everybody's business. We share an aspiration about what we can add and share, not what we receive and passively accept. The Campaign will be a hub for activity. We cannot end loneliness by ourselves, but we hope to enable and support the broad church of activists who, working together, can do so.
Our programme will build upon efforts already in hand. With our own growing convoy of partners, **the Campaign will:**

- **raise awareness** of the problems and why loneliness matters
- **build the evidence base:** gather the evidence, promote what works, and find the gaps
- **future-proof:** inform people to help them ensure stability in their own futures
- **look for vision and action from all:** work with others to create a vision of a society where loneliness in older age is ended – making sure individuals and organisations across society identify steps they can take, large or small, and argue for an explicit commitment from key actors. We will encourage individuals to act locally, with family, friends or local charities.

We will be calling for central government to:

- recognise that a big society cannot be a lonely society – by ensuring that older people continue to contribute and that neighbourly action between generations is actively encouraged
- Include loneliness as one of the social care outcomes that it measures and make sure loneliness is measured as part of the well-being assessment
- keep up the commitment to loneliness as a priority across a range of government policies: health, social care, transport and housing.

We will be calling for local authorities to:

- plan for great places to remain sociable and active
- maintain services which give people a life to lead
- provide health and care services which enable continued connections.

We will be calling for voluntary and community organisations to:

- be explicit about projects that target loneliness, and measure their impacts
- involve older people as contributors as well as recipients
- campaign with us to end the scourge of loneliness.

We will be calling for individuals and communities – all of us – to:

- challenge our assumptions about the connections we ourselves have with those in older age
- celebrate and value our older members of society
- cherish our connections and future-proof our lives for a better later life.

We are also calling for everyone to join the Campaign to End Loneliness.

For too long loneliness has blighted the lives of older people. It would be far from the truth to say nothing is being done about it. There is considerable concern, and much action. But we need to do more and we need to act together, drawing on the evidence and staying with it for the long haul. Devastating illnesses are not tackled overnight. But working together we can chip away at the problem, rooting out its causes and combating its effects. Together we can end loneliness.

3

The evidence

'The extent of loneliness has remained broadly static over the last six decades.'

Loneliness in old age: the UK perspective

Christina R Victor
BA, M Phil, PhD, AcSS, FFPH

Within the UK it was not until the Royal Commission of Enquiry into the Condition of the Aged Poor in 1895 that older people emerged as a distinct 'social problem' group differentiated from the general mass of paupers (see Thane, 2000; 2005). In the period between approximately 1890 and 1935 a number of studies and surveys examined the experience of old age and later life which reinforced the emergence of older people as a distinct social 'welfare' category. However, as Townsend (1959) observes, the pre-1945 'social' surveys focused predominantly upon poverty and unemployment and how this affected particular social groups, of which older people were one, and which resulted in Charles Booth, among others, advocating the creation of old age pensions.

From about 1930 onwards a body of work looked at the health status of older people in poor law institutions/public hospitals. Studies such as those by Marjorie Warren (1943; 1946) enumerated the levels of disability and illness and also showed the potential of specialised care and rehabilitation to enable older people to return back to the community. Such studies underpinned the development of geriatric medicine as a medical speciality (see Grimley Evans, 1997). The emergence in 1945–55 of a number of national and local social surveys investigating the health and social circumstances of older people reflects factors such as the recognition of the (numerical) importance of older people and the identification of the demographic 'time bomb' in the 1949 Royal Commission on Population (see also Phillips Committee on the economic and financial problems of the provision for old age) and the identification, by pioneering geriatricians such as Warren, of the number of older people suffering from chronic diseases languishing in public hospitals.

The earliest locally based survey is that reported in 1946 which examined the health and social circumstances of 1,001 individuals of pensionable age in Glasgow (Curran et al, 1945). The Nuffield Foundation (Rowntree, 1947) produced its report *The Problems of Ageing and the Care of Older People* based on a survey of 2,302 people aged 60/65+ living in seven areas of England and Wales (Lutterworth, Midhurst, Mid Rhondda, Wolverhampton, Oldham, Wandsworth and St Pancras).

This provides a link to the pioneering work of Booth and Rowntree and the 'political arithmetic' approach to social policy based upon the quantitative examination of society (or specific social groups). These two studies exemplify the post-war surveys in that they focus upon health problems. This is not surprising given that this time period coincided with the emergence of the new specialty of geriatric medicine within the new National Health Service. However, a novel interest was also expressed in the broader housing and social circumstances of older people. In part this reflects a humanitarian concern with the 'problems' of old age which has been a feature of much gerontological research on old age in the UK (see Higgs and Jones, 2009).

It is the Nuffield Foundation report (1947) and the Wolverhampton study of Sheldon that appear to be the first studies investigating the family life and social relationships of older people in the UK (see Thane, 2000). Sheldon, admirably, wanted to present an overview of 'normal' ageing and to enumerate the clinical and social aspects of older people living in the community. The Nuffield Foundation report confidently asserted that 'a distressing feature of old age is loneliness' (Rowntree, 1947, 52). While confident that this was a key issue of the experience of old age the report asserted that 'Loneliness is a complaint that is difficult to assess quantitatively' (Rowntree, 1947, 520). However, it is the study undertaken in Wolverhampton as part of the Nuffield Enquiry that we find the earliest empirical data describing the extent of loneliness and isolation in old age. Sheldon (and his readers) were rather surprised by the extent and intensity of the family ties of older people. Indeed the study by Townsend, *The Family Life of Old People*, was funded to test the robustness of the findings of Sheldon. Subsequently, Townsend developed an international approach to the study of loneliness in his work on old age in three industrial societies (Shanas et al, 1967) while Tunstall built upon the debate at national level (Tunstall, 1966) and with Townsend considered some of the more theoretical elements of this topic (Townsend and Tunstall, 1963).

Measuring loneliness Sheldon did not provide any theoretical or conceptual explanation for his measure of loneliness, or any information about the development and testing of the question which asked 'Are you: very lonely/lonely at times/never lonely?' This question does not demonstrate the robust psychometric properties of the scale developed by De Jong Gierveld (1987) and which is much less widely used in the UK. However, this type of 'self-evaluation' question broadly meshes with the key critical attributes of loneliness – of it being a subjective state that describes the dissatisfaction or deficits felt by individuals with the quantity and/or quality of their social relationships (see Bekhet et al, 2008). Such questions conceptualise loneliness as a one-dimensional concept and assumption that the variation between individuals is in the intensity of the experience rather than the nature of the experience itself, and are implicitly informed by cognitive theories of loneliness. Subsequently, this question, or variations thereof, has been widely used across a range of local and national surveys of old age in general or of specific facets such as nutrition. Hence, we can look at trends in reported levels of loneliness by older people in the UK over time. They are simple to use, appear to be highly acceptable to research participants and ask directly about feelings of loneliness. However, this type of question does not elicit information about the amount, nature, value or meaning of loneliness, or about its causes or consequences.

Trends in loneliness in old age in the UK

Table 1 summarises the results from a range of studies of loneliness in old age covering a span of five decades. There is considerable similarity in the percentage

Table 1 Selected British studies of loneliness

Author	Study area	Sample size (%)	Never lonely (%)	Sometimes (%)	Very/often/ always lonely (%)
(Sheldon, 1948)	Wolverhampton	400+	79	13	8
(Townsend, 1957)	London	203	72	22	5
(Tunstall, 1966)	4 centres	526	66	25	9
(Shanas et al, 1968)	Great Britain	2483	72	21	7
(Bond and Carstairs, 1982)	Clackmannan	1000+	74	19	7
(Wenger, 1984)	North Wales	683	76	19	5
(Jones et al, 1985)	South Wales Mid Wales	654 628	76 84	19 14	5 2
(Bowling et al, 1991)	Hackney Essex	1053 288			16 8
(Scharf et al, 2002)	3 deprived inner city areas	595	40	44	16
(Harris et al, 2003)	South London	1214	52	39	9
(Victor et al, 2005)	Great Britain	999	61	31	7

self-assessing themselves as always/often lonely. However, given the absolute increase in the numbers of people aged 60–65+ this represents a substantial absolute increase in the numbers of people experiencing loneliness. Over time we can see that it is the relative relationship between the sometimes and never lonely categories that have changed.

Correlates of loneliness

A plethora of variables have been statistically associated with loneliness. These include socio-demographic factors including age, gender and household size (essentially, living alone); social resources (time spent alone, links/contacts with family and friends; participation in cultural, sporting and social activities; marital status), health resources (psychiatric morbidity, chronic illness, sensory impairments, immobility, health rating and health expectations) and material resources (class, resources, tenure, education). However, many of these individual variables are inter-related: for example, gender, age, marital status and living alone are all associated. We therefore need to take these relationships into account when undertaking analysis (which is problematic if the study is 'under-powered', as many local studies are) (see Victor et al, 2009).

Conceptually and from a policy perspective we wish to distinguish those factors that help identify those 'at risk' of loneliness – essentially, identification or screening variables (such as living alone) – from those factors that may be causally linked to loneliness such as widowhood or entry of spouse into long-term care. However, as well as problems of variables being confounded, most of the analysis is based upon measuring loneliness at a single point in time. From a policy perspective, loneliness needs to be

deconstructed into its constituent types and then screening variables and protective/vulnerability factors sought (see section on life course perspective).

Key areas for further research

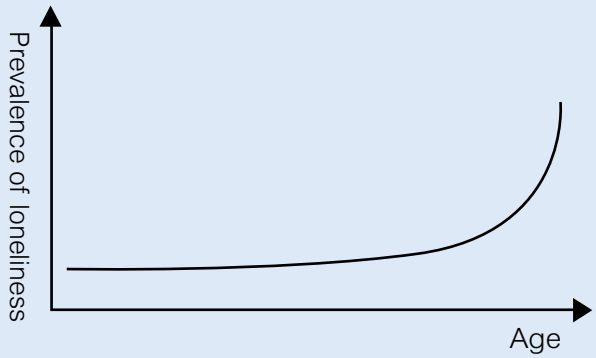
There are a number of areas for future research. Here we focus upon two: understanding loneliness across the life course, and studying loneliness among 'new ageing' populations.

Developing a life-course approach on loneliness

One key and persistent association is the perception that loneliness is a specific problem of old age. Thus Alcott, an American teacher and writer (1799–1888) observed, 'The surest sign of age is loneliness'. More recently, Cacioppo concluded that that loneliness is 'a condition that does not improve with age' (2009: 45) and that the 'physiological toll [of loneliness] likely becomes more apparent with aging. Since the body's stress hormones are intricately involved in fighting inflammation and infection, it appears that loneliness contributes to the wear and tear of aging through this pathway as well' (*Science Daily*, 18 August 2007). However, the relationship between age and loneliness is intriguing and, in the UK, is much less well studied than the prevalence in old age. The association between ageing and loneliness makes intuitive sense given the indicators, noted earlier, that are associated with loneliness: retirement from work, children growing up and establishing independent households, widowhood, the onset of chronic illness and increased time spent alone.

Age and loneliness Within the UK we have not rigorously examined the association between age(ing) and loneliness. There is a distinct lack of a life-course perspective and this is an area that would benefit from further research. If the hypothesis that loneliness increases or is associated with age is true, we will see a distribution like that illustrated in **figure 1** where the prevalence of loneliness is very low for younger people but rises dramatically with increasing age. This proposition has seldom been tested with empirical evidence. Is it always the case that older people are more likely to report feeling lonely than the younger generations? There is some limited evidence reporting a high prevalence of loneliness among adolescents. We might therefore hypothesise a non-linear relationship between age and loneliness.

Figure 1 A theoretical linear relationship between age and the prevalence of loneliness



Source: Yang and Victor, 2011

We can test this relationship between age and loneliness using the 2006/7 sweep of the European Social Survey. This research, conducted across 25 different European countries, looked at adults aged 15+. In 2006 it included this question on loneliness: 'How much of the time during the past week did you feel lonely?', with response options of 'None or almost none of the time', 'Some of the time', 'Most of the time', and 'All or almost all of the time' (see Yang and Victor, 2011). The UK sample included 2,386 individuals aged 15–85+ (see **table 2**). Overall levels of loneliness for the general population aged 65+ at 10 per cent are very similar to those reported by Sheldon and Townsend. If we look at trends by age, the distribution resembles the 'non-linear' model rather than the age-related linear model. This immediately raises a research question focusing upon what older people and those aged 15–25 have in common

Table 2 Loneliness by age: UK 2006/7

	All or almost all of the time	Most of the time	Some of the time	None or almost none of the time	N
≤25	2.3	5.7	28.8	63.3	264
25–34	0.93	3.8	26.6	68.8	346
35–44	2.3	4.3	22.1	71.4	444
45–54	2.8	2.5	21.7	73.0	359
55–64	3.1	6.4	21.1	69.5	393
65–74	5.3	3.6	19.7	71.4	304
75+	5.7	6.5	28.3	57.5	276

Source: European Social Survey

which renders them both vulnerable to loneliness and what factors are 'protective' to those aged 25–34 (see Mental Health Foundation, 2010).

Longitudinal studies of loneliness The majority of studies of loneliness/isolation in the UK are conducted at a single point in time and focus upon establishing the prevalence of and risk factors for these two phenomena. Such studies answer the question of 'what percentage of [older people] experience loneliness and 'which groups are at most (least) risk'. This is a very static perspective and can be seen to be problematic when Victor et al (2009) report that, compared with a decade before, 10 per cent of their participants were less lonely and 23 per cent were more lonely. Hence, there is a further related set of questions including 'Do individuals become more (or less) lonely as they grow older?' and 'Which groups of older people are most(least) likely to demonstrate improvement/deterioration?'. Dykstra et al (2006) note that there are very few studies where loneliness (or isolation) is the prime focus of investigation, has been evaluated longitudinally and in relevant study populations using a suitably powered study.

Within the UK there are only two published studies examining loneliness from a longitudinal perspective. Wenger and Burholt (2004) is based upon 45 survivors from the 500 participants recruited at baseline 20 years earlier. This illustrates one of the key problems of longitudinal studies – sample attrition, which results in the analysis being based upon an ever-decreasing pool of survivors with resultant issues of statistical power and bias. Harris et al (2003) followed up for two years a cohort of people aged 65+ registered with two primary care centres in South London which reduced in size from 1,658 participants at baseline to 1,214. Loss to follow-up varied by initial loneliness classification at baseline: 21 per cent of the 'never lonely' were 'lost' to follow-up compared with 31 per cent of the sometimes lonely and 43 per cent of the often/always lonely.

Analyses of such longitudinal data is not without its challenges. There are several types of analyses that can be undertaken – all of which offer different (and complementary) perspectives upon loneliness. We can examine the extent of loneliness at 'baseline'; the extent of loneliness at follow-up (possibly multiple follow-ups, as in the case of the North Wales Study by Wenger and Burholt, 2004), and changes in loneliness at different follow-up points as compared with baseline or earlier follow-up points. Wenger and Burholt (2004) propose a typology of loneliness that distinguished between the 'never' lonely; those for whom



loneliness in later life was a continuation of an established life pattern and those who improved/deteriorated. This is a typology that awaits verification using a larger data set.

We also need to establish the factors linked to the analysis of the onset/increase/decrease of loneliness within a life course or longitudinal perspective. What factors are associated with reduced levels of loneliness? If we can identify these factors this offers the potential to develop relevant interventions. As there is little consistency across studies in the variables included in these studies it is difficult to devise a definitive list with age/household size and marital status; lack of a confidant, dissatisfaction with relationships, change in partner status (bereavement/admission to care) and decreased health rating have all been linked with loneliness longitudinally. We can see a number of broad aspects of life in old age, if not specific variables, emerging and these link to key life events (bereavement/admission of a loved one into care); decreased social networks, problematic social relationships, psychiatric/psychological morbidity and poor self-evaluation of health (which may reflect unfilled expectations of their health status in old age). However, there is clearly

considerable more work to be developed in this area.

Loneliness and 'new ageing' populations

One key feature of the older population of the UK is that it is becoming increasingly diverse in terms of its social-demographic profile as new ageing populations reach maturity. Included within this group are people with chronic diseases such as cystic fibrosis and Down's Syndrome who, thanks to medical interventions, are now achieving much longer lives. In future decades we will see the entry into 'old age' of those with a much more complex and diverse 'marital/relationship' history than those older people studies by Sheldon or Townsend. This is important as marital status is clearly linked to loneliness/isolation.

Another group that challenges the presumption that the older population is predominantly white and Protestant is the ageing of our minority communities, most notably the migrants from the Caribbean and South Asia who came to the UK in the period 1950–75. This also leads to the need for ageing research to develop a more sophisticated international perspective. Clemens Tesch-Römer and Hans-Joachim von Kondratowitz (2006) have argued for a more theory-informed approach to comparative ageing research, while Daatland (2007) has pointed out some of the benefits of 'atheoretical' comparative studies: first, they add variability to knowledge base and enable us to pool perspectives; second, they help us to see things differently; third, they put problems and ideas on the political/policy agenda when they illustrate how things are done differently elsewhere as examples to be applauded or resisted.

Loneliness and ethnicity Several studies have illustrated that there are variations in reported levels of loneliness within Europe (see Walker and Maltby Scharf and De Jong Gierveld, 2008);) and between Europe and North America (van Tilburg, Havens, De Jong Gierveld, 2004). However, as yet there are few UK studies that have looked at the extent of loneliness (or indeed many other facets of later life) among our ageing minority communities. Loneliness has been a key theme in a range of qualitative studies focusing upon the experiences of a diverse range of older migrant groups including mid-life Bangladeshi women in East London (Phillipson et al, 2003; Gardener, 2006); older women from Asian, Caribbean and Polish backgrounds (Afshar et al (Ip et al, 2007), Korean elders in the United States (Lee, 2007) and South Asian elders in Canada (Choudhry, 2001) and a range of transnational seniors in the United States (Treas and Mazumdar, 2002).

Loneliness emerges as an important and significant issue in the lived experiences of ageing migrants from a range of differing communities across the developed world. There are few quantitative data describing the extent of loneliness among older ethnic minorities and which can be explicitly compared with levels of loneliness within the Western European/North American/Australasian context. In the UK Burholt reports that 62 per cent of South Asian respondents aged 55+ rated themselves as never/rarely lonely; 30 per cent were sometimes lonely and 8 per cent were lonely often or most of the time: rates remarkably similar to those reported for the general population (see Victor et al, 2008; 2005). However, there are no comparable data for the other key UK migrant groups although evidence from the United States suggests elevated levels of loneliness for Arab (Ajrouch, 2008), African-Caribbean (Livingstone et al, 2007), Hispanic (Friis, 2000) and Korean elders (Kim, 1999; Lee, 2007) compared with the general population: a similar pattern is reported for Iranian elders resident in Sweden (Moghari, 2003).

Victor et al (2009) report a comparison of the prevalence of loneliness across older people (aged 65+) from six key minority groups in the UK: African, Chinese,

Caribbean, Indian, Pakistani and Bangladeshi. The Indian group reported levels of loneliness consistent with the general population, with 8 per cent in both studies reporting that they were often/always lonely (see **table 3**). However, this rate was very much lower than those reported by all other minority groups. Almost a quarter (23 per cent) of older people from Caribbean backgrounds reported that they are always/often lonely, as did at least 40 per cent of Chinese, African, Bangladeshi and Pakistani respondents.

Assuming that these patterns are reliable, how do we explain the variations? In our UK example we might hypothesise that our minority communities have very much lower 'loneliness thresholds' and a higher expectation of social contacts than the general population, and hence much higher reported rates of loneliness. Again, this suggests another rich area for further research.

Table 3 Loneliness by ethnic group

	Loneliness rating (%)			
	Always	**Often**	**Sometimes**	**Never**
GB	2	7	32	61
Indian	4	4	30	62
Pakistani	0	50	34	16
Bangladeshi	0	40	50	10
African	16	34	50	0
Chinese	20	20	32	28
Caribbean	16	8	62	12
Birmingham				
All	4	4	30	62
Punjabi	1	8	35	56
Gujarati	7	3	26	64
Sylheti	4	2	27	67

Conclusion

This chapter has offered a broad overview of the evidence concerning the extent of loneliness among older people in the UK. It suggests that the extent of loneliness has remained broadly static over the last six decades but that there is much less consensus about the risk factors for loneliness in terms of those that we could use to identify those individuals 'at risk' and the factors that trigger or cause loneliness (and from which we could develop appropriate interventions).

Both Pettigrew and Roberts (2008) and Findlay (2003) consider that insufficient attention has been paid to the examination and understanding of loneliness in later life (see also Mullins, 2002). In this review we have identified two broad areas for research: investigating loneliness from a life-course perspective, and investigating loneliness among specific sub-groups who are now entering old age. While we have focused on minority elders there are other groups, such as those who have married more than once and the never-married, who constitute the 'new ageing' populations.

The perspective in this chapter has been predominantly quantitative but the questions and issues raised also merit investigation through a qualitative research lens in order that older people themselves can contribute to the development of our understanding of loneliness in later life and of appropriate interventions and policy solutions.

'The combination of old age and residence in deprived urban neighbourhoods increases the risks of feeling unsafe, dissatisfied and lonely.'

Loneliness: an urban perspective

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A range of research has explored cross-national differences in the prevalence of loneliness among older people. Such studies are valuable in highlighting the influence of contextual factors on older people's experience of loneliness, drawing attention, for example, to the role played by economic and social policy, and by cultural norms and expectations in shaping the quality of social relationships in later life. In this chapter, the focus is on a different set of contextual factors. Rather than examine differences in loneliness across nations, attention is given to within-nation variation in the distribution of loneliness. In particular, there is reason to explore the ways in which contrasting urban environments might influence older people's feelings of loneliness.

Elsewhere we have suggested that the heightened risk of loneliness may reflect the impact of at least three interrelated processes affecting urban areas, including those of the UK (e.g. Scharf and De Jong Gierveld, 2008).

First, older people might be adversely affected by the ways in which our cities and city neighbourhoods are being developed. Despite an ageing population, and the growing affluence of some groups of older people, there is a strong body of work that highlights the ways in which urban spaces are increasingly developed to meet the needs of affluent and more mobile younger consumers (Ipsen, 1999; Phillipson, 2007). As a result, the design of urban areas may inhibit the formation of the types of social relationships that can protect older people from loneliness. Initiatives such as the World Health Organization's Age-friendly Cities or, more recently in the UK context, Lifetime Neighbourhoods, implicitly recognise the value of improved urban planning to create environments suited to the needs of an ageing population.

Second, older people's subjective evaluation of the quality of their social relationships is influenced by the population dynamics of the places in which they live. The argument here is that stable and long-term social relationships are valued by older people and that such relationships are helpful in protecting people from the risk of loneliness. As a result, urban areas which are characterised by high rates of population turnover may be associated with a greater prevalence of loneliness. In the UK context, urban communities that have disproportionately high mortality rates (and lower average life expectancy) and relatively high rates of migration-related population change could pose particular risks for older people in terms of loneliness. The accumulated loss of family members, friends and neighbours – through either out-migration or death – is most likely to affect people living in particularly disadvantaged urban contexts (Ipsen, 1999; Phillipson, 2007).

Third, older people's loneliness is likely to be influenced by a broad array of social issues that arise within urban neighbourhoods. For example, they may become vulnerable as a result of a changing service infrastructure (Ruston, 2002; Scharf et al, 2000) linked, for example, to the closure of businesses, the loss of post offices or disruption to transport services. In neighbourhoods that are marked by high rates of crime, older people may become confined to their homes both during the day and, especially, at night, reducing their capacity to maintain

existing relationships or to establish new ones (Walters et al, 2004; Scharf et al, 2007). Especially during evenings, older people may be 'edged out' of town centres by the intimidatory presence of groups of younger people (Worpole and Greenhalgh, 1996: 13).

The fact that there is considerable diversity within and between urban areas in relation to such broad social change suggests that the prevalence of loneliness among older people will vary between urban neighbourhoods.

Loneliness in urban neighbourhoods: the (limited) evidence

Empirical research tends to confirm the impact of the broad urban trends outlined above in relation to older people's loneliness. Several studies show that the combination of old age and residence in deprived urban neighbourhoods increases the risks of feeling unsafe, dissatisfied and lonely (e.g. Scharf et al, 2004; van der Meer, 2006). In the UK in particular, the few studies that have been conducted in explicitly urban settings confirm that loneliness rates tend to be higher in deprived urban communities than in the country as a whole (Bowling et al, 1991; Victor et al, 2002; Victor and Scharf ,2005). While about 7 per cent of older people in the UK as a whole are lonely (Victor et al, 2005), Bowling et al (1991) reported a loneliness rate of 16 per cent in the disadvantaged community of Hackney; in a study of deprived neighbourhoods in three English cities, Scharf et al (2002) identified 16 per cent of older people as being severely lonely.

Rates of loneliness in deprived urban communities vary across an increasingly diverse older population, often in predictable ways. Hence, loneliness rates are higher among the oldest age groups (75+) and among those who are single and have never married or who are separated or divorced (Scharf et al, 2002). There is relatively little evidence in the prevalence of loneliness among people belonging to different black and minority ethnic groups in Britain. However, particularly high rates of severe loneliness were reported among older Somali and, especially, Pakistani people in areas of Liverpool and Manchester; respectively 24 per cent of older Somali and 48 per cent of older Pakistani people were severely lonely (Scharf et al, 2002).

Closer examination of geographical data suggests that even within deprived urban communities rates of loneliness among older people can vary considerably. Scharf and Gierveld (2008) show lower loneliness scores in deprived communities in London and Liverpool than in ostensibly similar communities in Manchester. This suggests that even between neighbourhoods that appear to be fairly similar in socio-economic terms, the local context influences the degree to which older people experience loneliness.

There is no straightforward explanation for such neighbourhood variation, and there is clearly scope for further research that explores environmental dimensions of older people's loneliness. The likelihood is that the factors identified in the introduction to this chapter play a key role in shaping older people's subjective evaluations of their social relationships. This encompasses features of the physical environment (such as housing conditions and the presence of amenities), population composition and the rate of population turnover, the local impact of social problems such as crime, and the influence of local policy-making. However, these factors are difficult to disentangle and, if viewed in isolation, prone to misinterpretation. It is necessary to caution against simplistic uni-dimensional interpretations of the source of neighbourhood influences on loneliness rates. In essence, we share the view of Parkes and Kearns (2006: 15), albeit when discussing health outcomes, that survey data increasingly need to be

'complemented by detailed neighbourhood case studies in order to elucidate potential mechanisms for neighbourhood effects on health for particular groups in specific residential contexts'. The same statement applies in relation to neighbourhood effects on loneliness in disadvantaged neighbourhoods in England.

Some evidence of the impact of neighbourhood contexts on older people's experience of loneliness can be drawn from the qualitative work undertaken by Scharf et al (2005) in their study of socially deprived urban neighbourhoods. In a report for the Social Exclusion Unit (Scharf et al, 2005), in addition to the close relationship between individuals' material circumstances and the experience of loneliness, the following factors affected a number of participants.

One female participant reported a very limited range of social relationships. Other than the son with whom she lives, she saw very little of her other two children (one worked long hours; the other's poor health prevented him from visiting). Her only regular contact was with a neighbour whom she helps: 'My neighbour's pretty ill and when her son goes out ... I go and sit with her ... to keep her company ... I do that every day. As I say, it's a bit of company for me because I don't see anybody and we have a cup of tea and a chat.' Also important for this participant was the closure of a range of local facilities: 'There's nowhere to go at night ... We've had five pubs closed in the past two years.' She was not attracted to the remaining pubs: 'You get people smoking cannabis and all the rest.'

Crime and anti-social behaviour affected the quality of some participants' social relationships, including those with family members. One severely lonely participant reported her distress at having been the victim of a domestic burglary at the hands of a grandchild: 'He [grandson] robbed me when I was in hospital in December. He took all my savings money out of the drawer – £180 I had saved up. He took away the heater, electric one, my husband's radio cassette, ate all my food.'

As expected, the loss of close family members and friends or the end of longstanding caring relationships also featured as factors in generating loneliness. For example, one male respondent had acted as the main carer of his mother for the ten years preceding her death. He had never married, and the demands of the caring relationship tended to limit his capacity to maintain existing contacts with friends and neighbours or to develop new relationships. Reflecting on the period following the death of his mother, he felt that his life now lacked company and that it was too late to do anything about the limited nature of his social relationships. Other participants continued to experience a sense of loss following the death of a spouse, a close friend or a neighbour; one man reflected on the death of a neighbour: 'We was company to each other. We'd cook a meal for each other sometimes. Now I miss her really.'

The absence or loss of proximate family or friends was often compounded by a view that the quality of relationships with local friends and neighbours was in some way deficient. This was especially evident in interviews with participants who were identified as being severely lonely. Older people who have spent a considerable period of their lives in a particular community are likely to have out-lived many friends and neighbours of their own age-group, and may experience difficulty in developing social ties with people who have moved into the community in more recent years: 'When you are elderly no one comes to see if you are all right. I mean there should be a welfare officer that knocks at the door ... We don't get help here. No one comes to see if you are all right.' Even where some older participants appeared to maintain relatively frequent contact with other people in their residential neighbourhood, there was a sense that such contacts were fairly shallow: 'I wouldn't

say friends. We laugh and talk and you know ... I don't really go to them with my problems ... We talk about the weather and talk about our arthritis and so on.'

Viewed alongside survey data, the qualitative data from the study of socially deprived urban communities are useful in helping to identify the different pathways that lead to loneliness in later life. In this respect, two general patterns can be discerned. First, some participants' loneliness can be viewed as a chronic condition: being lonely typically represents the continuation of longstanding difficult relationships with family members and limited relationships with friends or neighbours. Second, loneliness can be linked to the impact of particular life events or age-related losses. Becoming a widow, especially in mid-life, and the loss of close friends features strongly in the narratives of people belonging to this group (Scharf et al, 2005).

Suggestions for further research

On the basis of the foregoing, and an interpretation of the wider research evidence, there is ample scope to develop the knowledge base on older people's loneliness. This might include the following four points:

- **developing a greater awareness of environmental impact on loneliness** This is a challenging topic, since it requires careful research designs that are better able to distinguish cause and effect in terms of individuals' susceptibility to feelings of loneliness. Studies of a wider range of environmental contexts, including both urban and rural settings, would be particularly illuminating. Essentially the task is to explain why there is a higher prevalence of loneliness in urban communities in Manchester than in ostensibly similar communities in London or Liverpool.

- **longitudinal studies** Loneliness appears to vary across the life course as well as between age cohorts. If we are to understand the factors most closely associated with the onset of loneliness, then we need to draw on the investment that is being made in longitudinal studies of ageing. However, these studies should be encouraged to improve on their conceptualisation and measurement of loneliness. For example, ELSA (English Longitudinal Study of Ageing) has weaknesses in relation to the measurement of loneliness and also of individuals' social networks that play a crucial role in determining whether people feel lonely or not.

- **qualitative and multi-method studies** Many studies of loneliness tend to draw exclusively on survey data to examine the prevalence of loneliness and factors fail to explain how people came to experience loneliness and the impact of loneliness on individuals' daily lives. As such, survey data alone have limited potential to explain loneliness in later life. Qualitative studies, or those that link survey data with qualitative data, are likely to be of greater benefit in shaping the agenda for loneliness research in the years ahead. Such studies are also especially helpful in terms of their potential to influence on policy and practice.

- **viewing loneliness as one component of a set of interlocking forms of disadvantage** that may affect people as they age. In this respect, evidence points to the ways in which lack of material resources affect older people's ability to maintain the semblance of a 'normal' social life. Exploring the ways in which loneliness is related to other dimensions of social exclusion is likely to be important in terms of helping to shape policy making. For example, knowing that lack of income is closely related to loneliness for many people may focus attention on the preventative role to be played by income maintenance benefits.

'Male loneliness appears to be associated with an evaluation of the relationship with a partner, whereas women tended to evaluate relationships with a wider network of people.'

Loneliness of older men and women in rural areas of the UK

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The terms 'social isolation' and 'loneliness' have often been used interchangeably (Townsend, 1968; Victor et al, 2002; Routasalo and Pitkälä, 2003). However, research has indicated that these are distinct concepts (Forbes, 1996; Victor et al, 2000) and that some people may be isolated but not lonely, others both isolated and lonely, and some lonely but not isolated (Townsend and Tunstall, 1973; Wenger, 1983; Wenger et al, 1996; Wenger and Burholt, 2004). Two kinds of loneliness have been identified; emotional loneliness and social loneliness (Weiss, 1973). Emotional loneliness is the absence of a significant other with whom a close emotional attachment exists (e.g. a partner or best friend), while social loneliness is the absence of a social network consisting of a wide or broad group of friends, neighbours and colleagues.

In this chapter, the term 'loneliness' is used to describe a subjective measure of unwelcome feelings or perceptions on the part of the respondents that are associated with lack of contact with others or with a particular other. This may be as a result of retirement from employment, bereavement (on death of spouse or friends) or geographical separation. Therefore, loneliness is a measure of the state of mind of a person and of their negative feelings about their level of social contact (Wenger and Burholt, 2004; Weeks, 1994; Andersson, 1998; Walker, 1993; Victor et al, 2000). On the other hand, social isolation is a more objective concept that could be described on a scale with one extreme representing the absence of contact with other people *versus* high levels of social contact at the other extreme (Wenger and Burholt, 2004; De Jong Gierveld, 1998).

Loneliness is perceived to be a 'problem' associated with old age (Biggs, 1993). However, at any given time fewer than one-tenth of the older population are lonely. Research studies indicate that the prevalence of loneliness in the older population is 5–16 per cent, with a median of 9–10 per cent (Routasalo and Pitkälä, 2003; Victor et al, 2000; Andersson, 1998; Walker, 1993; Victor et al, 2000). Although loneliness has been found to increase with age (Victor et al, 2000; Townsend and Tunstall, 1973; Barretta et al, 1995; Fees et al, 1999; Tijhius et al, 1999), the prevalence in the older population is somewhat lower than the levels of loneliness in the current younger population in Britain and the rest of Europe (Victor et al, 2000; Walker and Maltby 1997). Also, there are no indications that the levels of loneliness experienced by the current cohorts of older people are any greater than for previous cohorts (Victor et al, 2000; Fees et al, 1999).

Studies have found that, aside from age, several other factors are associated with loneliness. These include living alone, never being married, widowhood, support network type, poor health, cognitive impairment or poor mental health and being female (Routasalo and Pitkälä, 2003; De Jong Gierveld, 1998; Holmén et al, 2000; Savikko et al, 2005; Victor et

al, 2005). A commonly held belief is that older people living in urban areas are more likely to be lonely than their peers in rural areas (Mullens et al, 1996). Rural settings have often been portrayed as fostering a particular kind of social integration that is supportive, friendly and neighbourly (Rowles, 1988; Tonnies, 1957). The notion of the supportive rural community is substantiated with evidence from rural studies (Krout, 1986; Salber, 1983; Burholt and Naylor, 2005). Participants in one study (Victor et al, 2005) perceived that low levels of loneliness in rural areas were due to there being more opportunities for social interaction in these settings than in urban areas. Urban areas are often perceived as more 'impersonal', with fewer possibilities for social relationships (Havens et al, 2004). In one study, people living in six English parishes thought that the association between loneliness and rurality was dependent on the degree of rurality. For example, they considered that there would be greater levels of loneliness in remote communities, such as some located in the Scottish Highlands, compared to the six English parishes in the study. People in the study also noted that it was likely that loneliness in remote rural areas would be hidden and generally go unnoticed. In such circumstances, there was concern that loneliness could affect particular groups such as women, adolescents and older people (Halfacree, 1995).

Despite the contradiction between community solidarity and loneliness in social representations of rural areas, in gerontology there have been few attempts to link loneliness to settlement types. There is very little research comparing levels of loneliness experienced by older people in rural and urban areas. The studies that do exist show that levels of loneliness are greater for older individuals living in urban areas (in the Netherlands) (Broese van Groenou and De Jong Gierveld, 1999) and family loneliness (DiTommaso et al, 2004; DiTommaso and Spinner, 1993, 1997; Cramer et al, 2000) is more pronounced in rural areas of Ireland (Drennan et al, 2008). Re-analysis of data (by the author) for six European countries (Burholt et al, 2007) shows that overall in Europe older people living in rural areas experienced significantly lower levels of loneliness than those living in urban areas (including suburban/metropolitan areas). When examined on a country level there were no significant differences in levels of loneliness between rural and urban areas in the Netherlands, Luxembourg or Italy. On the other hand, rural inhabitants in Austria, the UK and Sweden demonstrated lower levels of loneliness than their urban counterparts.

A majority of studies of loneliness tend to focus on the predictors or prevalence of loneliness for random population samples without taking into consideration environmental factors such as the degree of rurality in analysis (e.g. Victor et al, 2005; Routasalo et al, 2006). Fewer studies focus on loneliness in either urban or rural areas (e.g. in urban areas Townsend and Tunstall, 1973; Berg et al, 1981; Bowling et al, 1995; in rural areas Wenger and Burholt, 2004; Havens et al, 2004; Russell et al, 1997). However, a study undertaken in Canada examined the predictors of loneliness in urban and rural areas and demonstrated that there were some differences between the two environments. Living alone, a perception that future income is inadequate, poor health and low life satisfaction predicted loneliness in rural areas. On the other hand, being widowed and poor health predicted loneliness in urban areas (Havens et al, 2004). As this study was conducted in Canada it is not necessarily generalisable to the UK.

The lack of research on loneliness in rural areas in the UK is lamentable. Research in this area is important, as although studies predict a strong decrease in Europe's rural population (from 100 million in 2000 to about 75 million in 2030), the ageing of Europe's population will be even greater in rural areas compared to urban areas (Klijn et al, 2005). A literature review of

Table 4 Major contributing factors in four patterns* of isolation and loneliness, 1979–99

Not isolated/not lonely at any time	Became more isolated and more lonely over time
Indigenous to area Long-term residence in community Involvement in farming Married Not living alone Adult children living nearby	Death of spouse (during study or not long before) Death or other loss of relatives, friends, and/or close neighbours Deteriorating health Impairment of mobility, vision, and/or hearing At home alone for increasingly long periods during the day
Not isolated but lonely	**Isolated but not lonely/overcame loneliness**
Retirement migrant or moved during study Widowed Caring for dependent spouse with little help Living with adult child working full-time No one visits	Childless Self-sufficient personality EITHER satisfying relationships with friends/ neighbours OR lifelong isolates Spend Christmas alone by choice

*Always isolated/always lonely not enough data for analysis.

Source: Wenger and Burholt, 2004

social science papers published in the last decade (1998–2008) demonstrates that research on rural ageing has been dominated by studies undertaken in North America (Burholt and Dobbs, 2008). Published research regarding the loneliness of older people in rural areas of the UK is limited to work by Professors Wenger and Burholt.

Although research on loneliness by Wenger and Burholt focuses on rural areas only (with no comparison made to urban areas), it has added to the body of knowledge about the link between isolation and loneliness. In particular, analysis of data from the Bangor Longitudinal Study of Ageing (Wenger et al, 2001) has identified the factors associated with increases and decreases in loneliness and social isolation. The major contributing factors for four patterns of isolation and loneliness are presented in **table 4**. One of the most important features of this analysis is that loneliness can exist in the absence of social isolation, and isolation can exist independently of loneliness. This issue will be picked up later in the discussion regarding appropriate interventions.

Using a different set of rural data (Burholt, Gwynedd data, 2001–2), research has sought to examine the relationship between population density in rural areas and loneliness (Burholt, 2005). The study found that in rural areas levels of loneliness decrease with increases in population density. It also found some differences in the predictors of loneliness for men and women. For both men and women, living alone and poor mental health were strongly associated with increased loneliness. However, whereas for women loneliness was predicted by population density (i.e. increases in sparsity are related to increases in loneliness), and physical health (poor health is associated with greater levels of loneliness) neither of these factors predicted loneliness for men (see **table 5**).

Potential target groups

Despite the focus of this paper on the relationship between loneliness and rural environmental factors, it should be

Table 5 Predictors of self-assessed loneliness▲ and Wenger et al (1996) loneliness measure■ ('not lonely' (score of zero), 'medium' (a score of one or two) and 'high' (a score equal or greater than three))

	Self-assessed loneliness			Wenger et al (1996) loneliness measure		
	Men	Women	All	Men	Women	All
Living alone	***	***	***	*	***	***
MCS	**	***	***	*	***	***
Population density		**	**		**	*
PCS			*		*	**
Married			*			

Statistical significance of variables in the model: * $p \leq 0.05$; ** $p \leq 0.005$; *** $p \leq 0.001$ Source:[45]

▲Continuous variable ranging from 1 'never lonely' to 5 'lonely most of the time'

■Categorical variable representing 'not lonely' (score of zero), 'medium' (a score of one or two) and 'high' (a score equal or greater than three)

noted that Burholt's research showed that living alone and poor mental health (including depression) are strongly related to loneliness for both men and women (Burholt, 2005). These findings have been noted consistently in other research conducted in both urban and rural environments, (living alone e.g. Holmén et al, 1992, Samuelsson et al, 1998; mental health e.g. Mullins and Dugan, 1990; Prince et al, 1997; Holmén et al, 1999) and are vitally important to understanding which groups may benefit from interventions.

With regard to target populations in rural areas, the research conducted in North Wales suggests that older women living alone in sparsely populated areas and experiencing poor physical and mental health may be a target group for interventions. Although population density impacts on the levels of loneliness experienced by women it has no statistically significant effect on the levels of loneliness experienced by men. Other studies have linked male loneliness to divorce (Mullins et al, 1996) and lack of spouse or partner (Tijhius et al, 1999; Dysktra and De Jong Gierveld, 2004). In the Netherlands, male loneliness appears to be associated with an evaluation of the relationship with a partner (Tijhius et al, 1999),whereas women tended to evaluate relationships with a wider network of people (De Jong Gierveld, 1986). We may use this information to interpret some of the UK findings: as women may be more concerned with evaluating a wide network of relationships, the impact of sparsity (in old age), coupled with a decrease in functional ability has an impact on the capacity to maintain social relationships with people that may be scattered residentially over a large rural area. However, the dispersion of friends and relatives over a large area may not be so important to men, where self-reported levels of loneliness may be related to the quality of relationship with a spouse or partner, suggesting that a relationship with a 'significant other' is of prime importance to men's well-being. Thus, a potential target group is older men living in rural areas who are recently bereaved.

Wenger and Burholt's research and that of others (e.g. Hansson and Stroeve, 2007; Carr et al, 2006; Wolff and Wortman, 2006; Scrutton, 1995; Lund et al, 1993; Costello, 1990; Bowling and Cartwright, 1982; Croxall and Hillcoat-Nalletamby, 2009) has indicated that widowhood or the death of a 'significant other' can precipitate loneliness. Currently, bereavement services provided to older people are inadequate, highly fragmented and are largely confined to those who have accessed hospice or specialist palliative care services while the deceased was alive. Indeed, the vast majority of older people do not have the opportunity to access bereavement services, and many are offered no bereavement support whatsoever (Croxall and Hillcoat-Nalletamby, 2009).

Conclusions regarding interventions

Despite the identification of target groups for interventions, i.e. those people (in rural areas) who are most vulnerable to experiencing loneliness, the delivery of interventions in rural areas is not straightforward and responses may be hampered, because (a) the evidence on which to develop effective interventions is sketchy and controversial and (b) delivery is problematic and costly.

Two systematic reviews examining the effectiveness of home-based interventions to alleviate loneliness in older people have conflicting findings: whereas one (Elkan et al, 2001) concluded that home-based interventions worked, the other (Van Haastregt et al, 2000) found no conclusive evidence for effectiveness. A more recent systematic review (Cattan et al, 2005) found that home-based interventions were generally ineffective, but that other types of interventions were deemed effective in reducing loneliness (group interventions involving education or training, and social activities targeted at particular groups).

The research findings in Burholt's research (2005) suggest that women (but perhaps not men) residing in particularly sparely populated areas could be one of the target groups for social activity intervention. As men seem to be affected by emotional loneliness (lack of a significant other), it is unlikely that interventions to promote social interaction will have an impact on this dimension of their lives, unless the intervention specifically precipitates the formation of a new emotionally close personal relationship (perhaps through befriending). There may be scope to develop bereavement services for older people which incorporate opportunities for social support and interaction and the development of new relationships (Scrutton, 1995). Other interventions involving transport and recreation (Robertson, 1970) or community development through social activities and outreach (Pynoos et al, 1984) may also be particularly suitable for use in remote and sparse rural areas. However, at the moment evaluative evidence is not strong enough for these interventions to be recommended as useful tools.

Undoubtedly the evidence base for effective interventions will strengthen. None the less, additional problems are associated with delivery to rural areas. As with other services, it has been reported that there are problems with training staff to deliver services in rural areas (Hendry et al, 2008), and the cost of delivering interventions or services to remote and sparse areas is prohibitive (Commission for Rural Communities, 2006).

In conclusion, the concept of loneliness has been defined as experiencing unwanted feelings of inadequate levels of contact with others. Loneliness is therefore a negative experience, and older people may seek to deny or conceal it. Social isolation is often associated with loneliness, but is not always the cause of loneliness. Some older people have become accustomed to a solitary life for a range of reasons and may not seek to change the level of their potential contact with others. Where social isolation is associated with loneliness, it is likely that reduction of loneliness will also reduce unwelcome social isolation and *vice versa*, but it would be wrong to assume that solitude should always be a target for change. Solitude may be associated with a greater risk of undiscovered emergencies, but it is probably the risk that should be reducing and not the solitude itself, which may be cherished.



'About 20 per cent of the older population is mildly lonely and another 8–10 per cent is intensely lonely. Intense loneliness appears to be more prevalent among divorcees, (recently) widowed people, those living alone, those confronted with deteriorating health, and individuals in deprived areas.'

Alleviating loneliness among older adults: possibilities and constraints of interventions

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Nowadays, a significant proportion of European adults aged 65 and over lives alone: never-married women and men, divorced people, widows and widowers continue living independently in one-person households. Especially in Northern and Western Europe frequent visits by siblings, children and friends are prioritised above co-residence: 'intimacy but at a distance'. However, when help is needed adults living alone have to rely on persons outside the household. Consequently, living alone may be considered as one of the major risk factors for loneliness. Other key determinants of loneliness are deteriorating health and handicaps, having no children or having children who live a long distance away, and the death of siblings and friends, resulting in smaller social networks.

Several of the determinants of loneliness, such as the death of peers, deteriorating health and financial pressures, are directly related to events in later phases of life. Therefore research into loneliness of older adults is especially important. Both professionals and volunteer organisations are involved in activities to prevent and relieve older adults' loneliness. In doing so, institutions rely on their unique intervention strategies and co-operation between institutions is virtually absent. This brings us to a crucial question: which interventions are successful in preventing and reducing loneliness of older adults and which types are not? Findlay (2003) and Cattan et al (2005) concluded that there was little evidence that interventions targeted on loneliness were successful.

This chapter discusses loneliness intervention strategies, as well as one example of concerted action. The concept, determinants and the prevalence of loneliness are presented in advance of comment on the research outcomes.

The loneliness framework

The concepts of loneliness and social isolation

Loneliness has to be differentiated from social isolation, which concerns the objective characteristics of a situation and refers to the absence of relationships with other people. The continuum of objective social isolation puts social isolation at one extreme and social participation at the other. Loneliness, however, reflects an individual's subjective evaluation of his or her social participation or social isolation and is the outcome of the cognitive evaluation of having a mismatch

between the quantity and quality of existing relationships on the one hand and relationship standards on the other (Perlman and Peplau, 1981). Drawing upon the cognitive perspective of loneliness, analyses focus on the psychological processes that mediate between participation in social networks and the experience of loneliness (Dykstra and Fokkema, 2007). The opposite of loneliness is feeling embedded.

Types of loneliness

Weiss (1973) differentiated emotional loneliness related to the absence of an intimate figure (spouse, best friend) and social loneliness related to the absence of a broader, engaging social network (friends, colleagues, neighbours). In general, intense loneliness is related more to emotional than to social loneliness, while the combination of both places people at risk

Table 6 Items of the 11-item (original) and the 6-item (short) De Jong Gierveld loneliness scales

Please indicate for each of the statements, the extent to which they apply to your situation, the way you feel now. Please circle the appropriate answer.

Statement:		Emotional subscale Original	Social subscale Original	Emotional subscale Short	Social subscale Short
1	There is always someone I can talk to about my day-to-day problems		◆		
2	I miss having a really close friend	◆			
3	I experience a general sense of emptiness	◆		◆	
4	There are plenty of people I can rely on when I have problems		◆		◆
5	I miss the pleasure of the company of others	◆			
6	I find my circle of friends and acquaintances too limited	◆			
7	There are many people I can trust completely		◆		◆
8	There are enough people I feel close to		◆		◆
9	I miss having people around	◆		◆	
10	I often feel rejected	◆		◆	
11	I can call on my friends whenever I need them		◆		

Note Possible answers are 'yes!', 'yes', 'more or less', 'no', 'no!'. When face-to-face interviews or telephone interviews are conducted, it may be sufficient to offer the respondents only the answers 'yes', 'more or less' and 'no'. The model is based on the so-called cognitive theoretical approach to loneliness. This approach to loneliness places emphasis on the discrepancy between what one wants in terms of interpersonal affection and intimacy and what one has; the greater the discrepancy, the greater the loneliness. In developing the scale, item response models Rasch and Mokken (MSP) were applied to evaluate the homogeneity of the scale. Scale scores are based on dichotomous item scores; the answer 'more or less' always indicates loneliness. The score 0 refers to complete social embeddedness and the absence of loneliness. The score 11 refers to ultimate loneliness.

Processing the scale data entails counting the neutral and positive answers ('more or less', 'yes', or 'yes!') on items 2, 3, 5, 6, 9, 10. This is the emotional loneliness score. The emotional loneliness score is valid only if the missing emotional loneliness score (i.e. no answer) equals 0. Count the neutral and negative ('no!', 'no', or 'more or less') answers on items 1, 4, 7, 8, 11. This is the social loneliness score. The social loneliness score is valid only if the missing social loneliness score equals 0. Compute the total loneliness score by taking the sum of the emotional loneliness score and the social loneliness score. The total loneliness score is valid only if the sum of the missing emotional loneliness score and the missing social loneliness score equals 0 or 1. Further details and updates are available at http://www.scw.vu.nl/~tilburg/

Source: J. de Jong Gierveld and T. van Tilburg (2006). A six-item scale for overall, emotional and social loneliness: confirmatory tests on survey data. *Research on Aging*, 28, 582–98

of intense, despairing loneliness. Another differentiation is between short-term and long-term, sometimes hopeless, loneliness. The types of loneliness being addressed need to be recognised in any development of loneliness interventions.

Determinants of loneliness

Many factors, including income, physical and mental health and living in isolated rural areas, are associated with the size, composition and perceived quality of one's social network, and with loneliness (Cacioppo et al, 2006; De Jong Gierveld et al, 2006; Hawkley et al, 2008; Van Tilburg, 1998; Victor et al, 2005; Wenger and Burholt, 2004). Additionally, macro-level correlates of loneliness are important: the social norms and values regarding filial obligations (countries differ, for example, in prioritising co-residence of older persons or living independently), and the patterning of economic resources contributing to social integration or exclusion (Scharf, and De Jong Gierveld, 2008).

Measuring loneliness

Loneliness has a negative connotation and hence people tend to deny being lonely. The use of direct questions including the word 'loneliness' is likely to result in underreporting and for that reason the use of a loneliness scale without references to loneliness is recommended (Pinquart and Sörensen, 2001). Two well-known loneliness scales that have no explicit references to loneliness have been used in many research projects: the UCLA loneliness scale (Russell et al, 1980) and the De Jong Gierveld loneliness scale (De Jong Gierveld and Van Tilburg, 2006). The second scale can be used as a one-dimensional loneliness measure, but researchers can also choose to use two subscales, one for emotional and one for social loneliness.

The prevalence of loneliness

On the basis of interviews in the Netherlands and the UK, it is estimated that about 20 per cent of the older population is mildly lonely and another 8–10 per cent is intensely lonely (Victor, 2005). Intense loneliness appears to be more prevalent among divorcees, (recently) widowed people, those living alone, those confronted with deteriorating health, and individuals in deprived areas (Hawkley et al, 2008).

Alleviating loneliness

Most researchers into loneliness differentiate three main ways to reduce loneliness:

- reducing the perceived discrepancy between actual and desired relationships by increasing the number and quality of the relationships to the desired level
- reducing the perceived discrepancy by decreasing the standards held for relationships to the level of reality
- reducing the perceived discrepancy by reducing the effect of the discrepancy, e.g. by accepting these feelings or by seeing loneliness in perspective.

In general, older adults are prepared to cope with loneliness – such as by enlarging their network of personal relationships with new acquaintances and friends or by improving the quality of already existing relationships. An example: immediately after the deaths of their partners 60 per cent of widows and widowers were shown to be lonely. Thanks to efforts of the widowed persons themselves and the support of children, friends and neighbours in the period following the death of the partner, loneliness decreased to a certain extent: nine months after bereavement about 40 per cent of widowed women and men were still lonely, but 20 per cent succeeded in recovering from loneliness.

In cases of severe loneliness and a small or not optimally functioning personal network, or in cases of severe handicaps and chronic illness, others are needed to provide support and guidance to overcome loneliness. Volunteer organisations are the first to step in. Members of churches and members of neighbourhood volunteer organisations arrange regular visits to

sick and disabled adults in their homes, or organise meetings where lonely people can meet other people. Additionally, many professional interventions have been oriented towards reaching and motivating older adults to participate in community therapeutic settings in order to decrease loneliness.

Loneliness interventions

The effectiveness of loneliness interventions is unknown, with only a few exceptions (Stevens et al, 2006). In this context, the Sluyterman van Loo foundation, a Dutch welfare organisation for older people, asked researchers to investigate the effectiveness of 18 interventions (Fokkema and Van Tilburg, 2006). Half of the interventions were oriented towards an individual approach such as visiting lonely adults in their homes, and the other half involved group-oriented approaches, such as courses and group activities in nursing homes.

The resulting measurement of the effects clearly showed that no more than two projects succeeded in their mission. The first project, Esc@pe, was designed to reconnect chronically ill people with society via the internet (Fokkema and Knipscheer, 2007). The second project aimed to promote friendly contacts between residents of an assisted living complex via small-scale group activities such as meeting each other at coffee time and participation in discussion groups (Fokkema and Van Tilburg, 2006).

Semi-structured interviews were organised with project leaders, field workers and participants to find out more about the intervention processes. The overall conclusions of the researchers encompassed, among many others, the following:

- in starting the interventions, organisations failed to thoroughly examine the loneliness problem – asking, for example, to what extent people suffered from feelings of emotional and social loneliness and which factors gave rise to this situation
- in most cases a careful weighing of pros and cons of the planned intervention did not take place; only one possible intervention was considered
- in planning and organising the interventions, project leaders did not profit from the knowledge of interventions as available in other organisations
- interventions were almost exclusively oriented towards broadening the social network of the participants and, hence, were predominantly oriented towards alleviating social loneliness.

The researchers concluded that most volunteer organisations and professionals were too optimistic regarding the possibilities of successfully addressing loneliness.

A Dutch example of concerted action

Recognising the difficulties and constraints for loneliness interventions, and that the ultimate goal is the improvement of well-being of older adults, the challenge is to facilitate organisations in upgrading their loneliness intervention strategies, while fully respecting the mission of each of these organisations. Thorough preparation is needed prior to interventions, and optimal coherence should be facilitated between causes and types of loneliness on the one hand and, on the other, the type of intervention selected to support older lonely adults.

In this context it is worth mentioning the activities of the Netherlands' Coalition 'Erbij', the National Coalition against Loneliness. Recognising the scale of loneliness in society, 14 welfare organisations and companies involved in the problem have joined Coalition 'Erbij' in an attempt to tackle loneliness decisively.



Coalition Erbij* intends to prevent and alleviate loneliness by (among other things):

- increasing the awareness, knowledge and understanding of the Dutch population about loneliness. An anti-loneliness week was launched in September 2010 to raise awareness among men and women, young and old, about the risks of loneliness, the taboo of loneliness and the ways to overcome these pitfalls. Many journalists and radio stations and several TV companies paid considerable attention to these activities and in discussion programmes several members of Coalition Erbij have been interviewed to raise their voices against loneliness
- increasing knowledge and commitment of Dutch policy-makers at both the national and the local level. Disclosure of recent research into the incidence of loneliness and stereotypical views of it has been presented to representatives of the government. The representatives have been offered the opportunity to express their voices publicly, via TV, to promote policies aimed at alleviating loneliness
- as a coalition, incorporating large numbers of professional workers and volunteers, co-operating closely with each other and using every possibility to learn from experiences of other organisations. In this context it is worth mentioning that the effectiveness of four loneliness interventions is under investigation at this moment. Members of the Coalition will be informed about the outcomes of the intervention research and will discuss the outcomes in the light of a future work plan.

In doing so, the constituent members of the Netherlands' National Coalition Erbij will be in an optimal position to guarantee that their actions addressing a wider audience, as well as policy-makers at national and local levels, will impact on the prevention and alleviation of loneliness among the older population.

*The word 'Erbij' can be translated as connected or included. In this coalition participate, among others: Sunflower Foundation (40,000 volunteers provide adults who have physical handicaps and are at risk of loneliness with possibilities to contact others, either via home visits or day activities and holidays), Humanitas (Dutch association for social services and community structure), Salvation Army, Mezzo (Dutch Association for Carers and Voluntary Help), Dutch Council of the Chronically Ill and Disabled (the umbrella organisation, consisting of associations of people with a chronic illness or disability), Sensoor (providing confidential attention 24 hours per day), the Netherlands Foundation of Mental Health, the National Elderly Foundation, the Council of Churches in the Netherlands, FORUM, ANGO (the Netherlands Organisation of Disabled People) and KPMG ('Erbij' was started on the initiative of the director Corporate Social Responsibility of KPMG, Jan Van den Herik).



'Lonely older people are as different as any other individuals, and have different needs and expectations.'

Alleviating social isolation and loneliness in older people

Mima Cattan, Northumbria University

This chapter focuses on interventions to prevent and alleviate loneliness and social isolation in older people. In addition, it reflects on some of the findings from recent research regarding specific groups of older people and their experience of loneliness. Finally, some proposals for collaborative action are presented.

What follows is based on the following premises.

Loneliness is a subjective, negative and unwelcome feeling of not having a close companion, desirable friends or social contacts. It is characterised by perceptions and experiences of not belonging, being left out, boredom, sadness etc. (Victor et al, 2000; Scharf and De Jong Gierveld, 2008). Some research suggests that loneliness is a biological construct, which signals a deficit in the same way as hunger or thirst (Masi et al, 2010).

Social isolation has been defined as an objective state that can be measured by the number of contacts and interactions between individuals and their wider social network. Increasingly it would seem that isolation is a social construct, which is more than the sum of an individual's personal contacts (Andersson, 1998; Scharf and De Jong Gierveld, 2008).

Loneliness and social isolation are frequently used interchangeably, particularly in practice but also in research. Because of this, some interventions, by default, target both.

An important distinction when developing interventions is the duration of the experience: transient loneliness; situational loneliness following a change in life circumstances; chronic loneliness – an ongoing, enduring experience (Cattan, 2010).

Several aspects of older people's characteristics and experiences of loneliness are relevant when developing interventions: demographic characteristics; context and culture; perceptions of personal control, coping and feelings of dependency; the experience of major life events; personal resources, such as mental health and disability (see for example Savikko et al, 2005; Sundström et al, 2009; Victor et al, 2009).

Interventions to alleviate and prevent loneliness

A large number of interventions have been developed to alleviate loneliness in older people, ranging from 'hi-tech' internet or phone-based services to small low-cost self-help groups, and have been evaluated over time. Some are theory-driven while others have evolved through practitioners' experiences and local knowledge (Cattan, 2010). Most such interventions set out to help lonely individuals establish satisfying interpersonal relationships, prevent loneliness from evolving into more serious health problems or prevent loneliness from occurring in the first place.

In 2005, our systematic review showed that effective interventions shared several characteristics:

- they were group interventions with a focused educational input, or provided targeted support activities

- they targeted specific groups, such as women, care-givers, the widowed, the physically inactive, or people with serious mental health problems
- they were representative of the intended target group
- they enabled some level of participant and/or facilitator control or consulted with the intended target group before the intervention
- they were developed and conducted within an existing service.

Many participants were identified through statutory services, e.g. GPs, social services, housing waiting lists, or through press advertisements (Cattan et al, 2005).

The review also found that the impact of one-to-one support was less clear. This may have had more to do with the study design and methods than with the actual intervention. Policy-level interventions had not been evaluated with regard to reducing loneliness.

Groups

Groups meet a variety of needs such as enjoyment, activity and social integration. Often the emphasis is on shared enjoyable activities rather than on reciprocal support. Some interventions are intended to help individuals identify activities that can be enjoyed alone. Older men are more likely to participate in task-focused activities than in what they perceive as social support or social network activities. Many interventions use indirect approaches, which are not perceived as social network activities or as having the intention of reducing social isolation and loneliness (Cattan et al, 2003).

The systematic review (Cattan et al, 2005) identified two types of groups: those providing social support and those that had an educational and problem-solving emphasis.

Group interventions providing social support included social activation in communal living settings with participant-planned and -led activities, bereavement support for recently widowed older people, therapy-based discussion groups for older people with mental health problems, and peer- and professionally-led counselling/discussion groups for primary carers.

Group activities with an educational and problem-solving emphasis included targeted small educational groups for older women who lived alone, structured skills training for lonely older women, and structured physical activity, such as walking and exercise groups. Interestingly, some of the interventions showed an increase in social contacts as well as a decrease in loneliness.

A recent randomised controlled trial found that psychosocial group activities, where the activity was determined by the participants, improved subjective health. However, despite a significant increase in the number of friends and improvements in psychological health, there were no differences between the groups with regard to loneliness (Routasalo et al, 2009).

Other research has suggested that activities such as gardening projects, healthy eating groups, art, music and dance are effective, although further evaluation is still required (Cattan, 2006).

It is frequently assumed that if people participate in an activity it is acceptable and attractive to them. However, some older people will make do with activities and services that do not meet their social activity or social support needs, simply because there are no other options (Cattan et al, 2003).

Volunteering and befriending

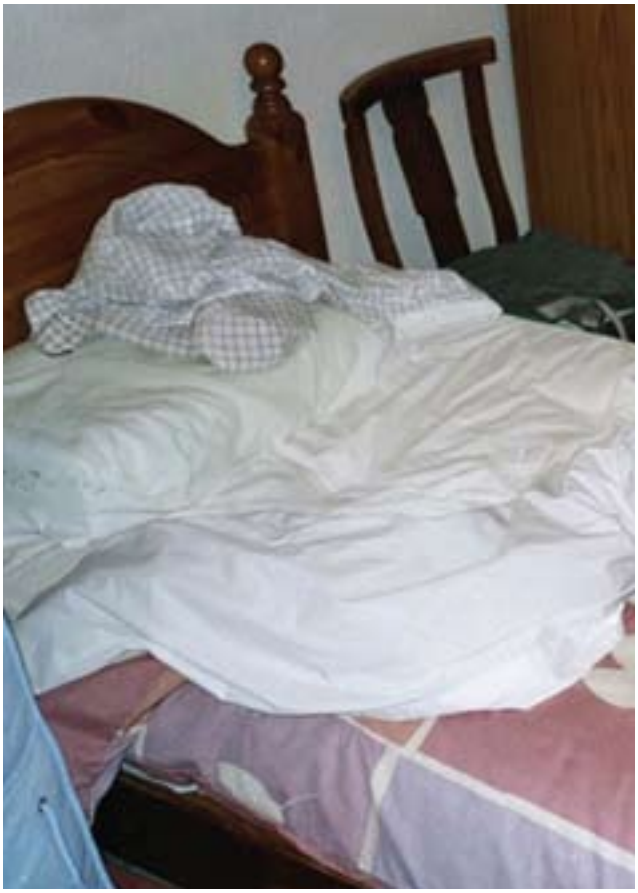
Volunteering is frequently put forward as an effective way of maintaining mental well-being in later life. Volunteering undoubtedly has beneficial effects because of the social and/or reciprocal aspects of the activity. However, little is known about the effectiveness of volunteering on reducing loneliness for the volunteer (Cattan, 2006; European Union, 2010).



Qualitative research has shown that older people respond favourably to befriending and home visiting because it provides someone to share interests and worries with as well as practical help, social support and companionship. The importance of reciprocity is emphasised, which may be more likely when the visitor/caller and the 'recipient' share a common culture and social background, and have common interests. Befriending may therefore be of value to both the (older) volunteer and the older person receiving the service (Cattan et al, 2010). To date, research has been unable to demonstrate that one-to-one support (befriending) is effective in alleviating loneliness in older people.

Use of technology

The effectiveness of technology, such as the internet or telephone networks, to reduce social isolation and loneliness has increasingly been investigated (Fokkema and Knipscheer, 2007), but the results remain ambiguous. There are indications that telephone and internet support groups may be effective in reducing loneliness among housebound older people (Stewart et al, 2001), caregivers (Stewart et al, 2006; Torp et al, 2008), older people living with HIV/AIDS (Heckman et al, 2006) and people in congregate housing (White et al, 2002). Research suggests that email and the internet may be used for different purposes: email is mostly used for social contact, whereas the internet is used for practical purposes, such as finding information or just passing time. One study found that using the internet to communicate with family and friends was associated with a reduction in social loneliness, whereas using it to find new friends was associated with greater levels of loneliness (Sum et al, 2008). It has been suggested, tentatively, that mobile phones or social networking sites might help to decrease individuals'



feelings of loneliness. However, little is currently known about how different groups utilise mobile phones and most research to date is with young adults.

For older isolated and housebound older people telephone befriending and support groups can provide the means to have social contacts and to reduce their isolation and loneliness (Cattan, 2002; Andrews et al, 2003). Some research has also shown that people who choose not to join groups like the anonymity of the telephone group. Although qualitative research clearly shows the value of telephone befriending for isolated older people, the association between loneliness and telephone interventions remains unclear.

Indirect activities

Many widely provided services and activities that are not directly intended to impact on loneliness have not been evaluated or have been inadequately evaluated, despite anecdotal evidence of their effectiveness in alleviating loneliness. For example, research regarding the influence of companion animals has to date been inconclusive, mainly due to methodological flaws (Duvall Antonacopoulos and Pychyl, 2010). Likewise, the impact of the physical and social external environment has not been evaluated. It has been suggested that the provision of adequate public transport and accessible, 'safe' social venues (parks, libraries, internet cafés, garden centres and shopping malls) would reduce social isolation and loneliness (Fokkema and Knipscheer, 2007). It has even been suggested that hairdressers could provide lay support for socially isolated people who might not access other services (Cattan, 2006).

Reflections on recent research

The author has recently completed three studies involving housebound older people (evaluation of telephone befriending for Help the Aged, Cattan et al, 2010), older people from ten ethnic groups in Bradford (for JRF, Cattan and Giuntoli, 2010) and frail older people with sight loss in care homes (Cattan et al, 2010). In the evaluation of telephone befriending older people reported that their mood and well-being improved and activity levels increased. Most importantly, telephone befriending seemed to help isolated older people re-connect with the outside community and to provide them with a chance to engage in ordinary conversation. Although loneliness was not the main subject of the Bradford study, several participants described missing family and friends, not seeing anyone for days and feeling very lonely. The only relief consisted of occasional visits to a community centre. Visually impaired older people living in care homes were found to be highly dependent on family and friends for emotional support. The (in)ability to join in social conversations was described as a major reason for staying in their rooms and not interacting with other residents. For some this was compounded further by hearing loss and other physical health problems.



Suggested actions to tackle social isolation and loneliness

The first thing to acknowledge is that lonely older people are as different as any other individuals, and have different needs and expectations. Loneliness can also fluctuate, which means that support/activity needs vary.

Some intervention studies have been very costly to implement. Many of the less rigorously evaluated interventions are 'already there', inexpensive and acceptable to older people.

A widely held but erroneous assumption is that minority ethnic populations will 'look after their own'. Older migrants/minority ethnic older people can be very isolated and lonely, with little access to external support or help.

There is a large group of older people with different levels of 'frailty' living in sheltered housing/care homes whose needs for social support and social activity are not being met. It would seem that the specific factors pertaining to loneliness of older people with, for example, sight or hearing loss are not acknowledged.

Telephone befriending/friendship circles are examples of low-cost technology interventions which are highly acceptable among older people who receive such services. However, the evidence still remains unclear and their implementation is patchy and ad hoc.

The role of volunteering in reducing loneliness is not clear. In the light of various government agendas this should perhaps be explored.

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