

Focus On...

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Centre for Ageing Research
and Development in Ireland



Loneliness and physical health

Introduction

Loneliness is an important issue as it affects the physical and mental health of older people. The UK Campaign to End Loneliness¹, launched in 2011, states that while people are aware of the emotional problems of loneliness, few recognise the physical effects it may have. Understanding loneliness in public policy terms is difficult as it is a subjective state. Yet it is also an important issue for older people given the potential effects on mental health and physical well-being. This edition of CARDI's *Focus on* series concentrates on these issues and examines some potential policy approaches to tackling loneliness in the older population.

¹ <http://www.campaigntoendloneliness.org.uk/>

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Key findings

- Loneliness affects the physical health of older people, affecting recovery from stroke and the frequency of emergency hospitalisations as well as causing depression and stress (Boden-Albala et al., 2005) (Molloy et al., 2010) (BBC News, 2011).
- A 2011 report in ROI found that loneliness was the biggest problem for older people living alone (Walsh & Harvey, 2011). In NI in 2005, loneliness was found to be the biggest problem after the fear of crime (Evason et al., 2005).
- Factors that can contribute to loneliness include living alone; advancing age; widowhood; low levels of education or income; poor health; and infrequent contact with family (Holmen & Furukawa, 2002) (Savikko et al., 2005) (Drennan et al., 2008).
- As loneliness is a subjective feeling, it is difficult to tackle the problem directly, but governments can take action such as promoting social inclusion, encouraging volunteering, ensuring adequate incomes in retirement and improving health outcomes for older people.

Defining loneliness

Loneliness has been described as “the subjective, unwelcome feeling of lack or loss of companionship” (Cattan et al., 2003). It was categorised by Weiss (1975) into two distinct types: emotional loneliness and social loneliness. Emotional loneliness is personal, relating to satisfaction with existing opportunities to socialise while social loneliness is where people feel they do not have a wide social network, with support from friends or allies in times of distress (Weiss, 1975).

Loneliness is often confused with social engagement, with the belief that getting older people more involved in their communities or building up social networks will alleviate the problem. However, people who are fully engaged with their communities and have a wide social network can also feel lonely, while people who live on their own in isolation from society may never feel lonely. The quality of social relationships plays an important role in whether or not people suffer from loneliness, as does their own life experience (Hole, 2011).

Given the subjective nature of loneliness, it can be difficult to classify in terms of tackling the problem. It can be seen as a personal issue only, a mental health issue, a public health issue which requires policy involvement, or even an issue

to be tackled by local communities. It is important to raise greater awareness of the issue of loneliness, particularly the effect it can have on physical as well as mental health, and the adverse effect it can have on the quality of life of the older population.

Loneliness and health – some research findings

A US study conducted in 2005 found that people who had suffered a stroke and were socially isolated had a 40% greater risk of having another stroke within five years, compared to people who were not isolated. The potential explanations for this were poor compliance to medication, depression and stress among socially isolated people (Boden-Albala et al., 2005). By comparison, factors such as high blood pressure, a lack of exercise or a family history of coronary artery disease only increase the risk of stroke by between 10% and 30% (McCall, 2009).

A study of people aged 65 and over in ROI and NI published in 2010 sought to examine whether loneliness was independently associated with emergency hospitalisation and planned inpatient admissions to hospital. 11% of the sample had an emergency hospitalisation and 15% had a planned hospital admission. 42% reported being bothered by loneliness. The conclusion was that loneliness was independently associated with emergency hospitalisation but not planned inpatient admissions (Molloy et al., 2010).

There is evidence that positive social support accelerates and improves patient recovery from conditions such as cancer, cerebrovascular disease and cardiovascular disease (Seeman, 2000). A positive social environment can also be as helpful to a patient diagnosed with a chronic disease as information or instrumental support (Arora et al., 2007).

A study of people aged 65 and over conducted in Dublin in 2009 found that a sense of well-being, depression and hopelessness were all independently associated with loneliness and a non-integrated social network (Golden, et al., 2009). The results of a US study published in 2012 show that loneliness not only increases the risk of heart disease, but accelerates the process of ageing (Booker, 2012).

Loneliness in ROI and NI

A 2011 report by the Society of St. Vincent de Paul found that social loneliness was the biggest single issue for older people living alone. The study also established a link between a reduced level of human contact and a reduction of public services (e.g. post offices, buses and trains) and the use of automation in providing customer services (for example automated telephone help lines) (Walsh & Harvey, 2011).

The Irish Longitudinal Study on ageing (TILDA) finds that women were found to be more likely to feel lonely than men while less educated people were also more likely to feel lonely. A connection was also established between loneliness and health as individuals who reported excellent, very good or good health were less likely to feel lonely than those with poorer self-reported health (TILDA, 2011).

However, the study finds that not all people who are less socially engaged are lonely. 60% of people who could be considered objectively socially isolated stated that they never feel isolated. The findings also show that women visit family and friends more frequently than men, at the same time as being more likely to feel lonely. This suggests that loneliness is not related to social engagement in any simple way (TILDA, 2011).

Evidence suggests that loneliness is a major issue facing older people in NI as it is in ROI. In a study of older people in NI conducted in 2005, loneliness was considered to be the second biggest problem facing the over 65s, after the fear of crime (Evason et al., 2005). A survey of older people living in Belfast found that almost one-fifth (19%) never went out to the shops and 38% said that they never went out to use local services such as the post office or library. Problems with health and mobility were identified as the biggest factors in restricting and preventing older people getting out and about (Engage with Age, 2010).

Causes of loneliness

As loneliness is a subjective psychological condition, it can be difficult to define and measure. Being alone does not by itself lead to social isolation or loneliness, while having a strong social network or high level of social engagement does not necessarily combat loneliness.

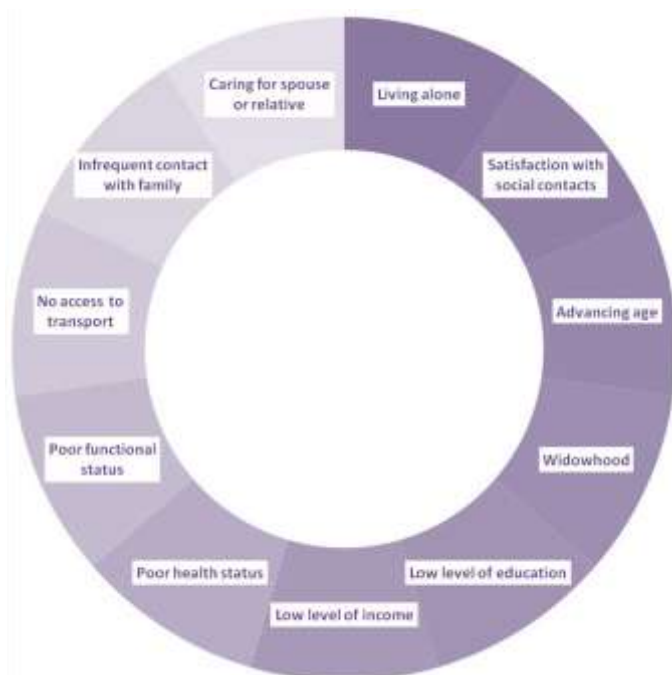
A longitudinal study of a group of over 75s in Sweden in 2002 showed the strong connection between levels of satisfaction with social contacts and loneliness (Holmen & Furukawa, 2002). A 2005 Finnish study of over 75s found that loneliness was associated with living alone or in a residential home, advancing age, widowhood, a low level of education and a low level of income. In addition, poor health status, poor functional status, poor vision and loss of hearing increased the prevalence of loneliness. The most common subjective causes for loneliness were found to be illnesses, death of a spouse and lack of friends (Savikko et al., 2005).

A 2008 ROI study found that some predictors for social loneliness included greater age, poorer health, living in a rural area and lack of contact with friends. Some significant predictors of emotional loneliness were living in a rural area, being male, having a lower income, being widowed, having no access to transport, infrequent contact with children or relatives, and caring for a spouse or relative at home (Drennan, et al., 2008).

In NI, a study examining social isolation in Belfast found that people who were divorced or separated experienced the highest levels of loneliness, followed by people who were widowed. Older people with poorer health tended to report more feelings of loneliness (Engage with Age, 2010).

A 2011 Dublin study of the risk factors associated with loneliness found that having high levels of social support can mediate the risk of both emotional and social loneliness. Interventions targeting depression, perceived stress, living arrangements and neuroticism can increase the effect social support has on emotional loneliness. Building up social support itself can help to combat social loneliness (Schnittger et al., 2011).

Figure 1: Factors contributing to a risk of loneliness in the older population



Source: (Savikko et al., 2005) (Drennan, et al., 2008) (Schnittger et al. 2011)

Policy interventions and loneliness

The research cited clearly indicates that loneliness can have serious mental and physical impacts on older people yet the complex nature of the issue makes it difficult for governments to promote a single policy or strategy to combat these effects. However, some elements of the issue can be tackled for example:

- Ensuring older people have an adequate income to support their lifestyle;
- Encouraging life-long learning to improve educational levels;
- Providing access to health and social service;
- Encouraging greater flexibility in employment policies to allow those who wish to work longer to remain in the labour force.

The forthcoming strategies for ageing in NI and ROI provide opportunities to address the important and complex issue of loneliness.

At an individual level, volunteering or participating in clubs can help to build a social network and strengthen social relations. Mental health charities work to raise awareness of the problems associated with loneliness, and also provide and support services to encourage people to engage with their communities

(The Independent, 2010). A report by the UK Mental Health Foundation suggests three goals in combating loneliness: to establish satisfying personal relationships; to prevent loneliness from becoming chronic; and to prevent loneliness in risk populations (Mental Health Foundation, 2010).

Interventions to alleviate loneliness often depend on the person involved. For example, social supports such as providing day centres, promoting volunteering or offering befriending services can help with the problem for some older people, but others may get no benefit from them. Promoting social activities such as walking clubs is important, but some older people may lack the confidence and health to participate in them (Cattan, 2010).

Technological advances can also provide new tools to help older people cope with loneliness. Video calls using services such as Skype has been shown to reduce loneliness in older carers, while emails and the internet can reduce loneliness in the chronically ill or physically disabled (Cattan, 2010). The internet is an important tool for keeping in touch with family and friends, particularly young grandchildren, but it is also vital that older people do not lose touch with the physical community, including face-to-face meetings (Morgan, 2011).

Conclusion

Loneliness and social engagement are often used interchangeably, with the belief that increasing participation in social activities will decrease loneliness. However, some older people who live in social isolation do not consider themselves lonely, while people with strong social networks and relationships can still suffer from loneliness. It is a subjective state that requires different approaches at individual, community and policy levels for different people.

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