

Changes in Levels of Social Isolation and Loneliness among Older People in a Rural Area: A Twenty-Year Longitudinal Study

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RÉSUMÉ

Dans l'étude longitudinale Bangor Longitudinal Study of Ageing (BLSA), menée au pays de Galles en région rurale de 1979 à 1999, on a suivi une cohorte de plus de 500 survivants sur une période de 20 ans. Les données quantitatives et qualitatives tirées de l'étude ont permis d'isoler les facteurs qui intensifient ou atténuent la solitude et l'isolement social. L'étude portait sur une population échantillon, un suivi étant effectué tous les 4 ans. De 1983 à 1987, l'étude s'est concentrée sur 30 personnes qui avaient 75 ans et plus en 1979. Pour mesurer la solitude, l'équipe de chercheurs a utilisé l'échelle habituelle, ainsi qu'une mesure globale spécialement mise au point pour la circonstance. L'isolement social a été mesuré de la même façon en utilisant la mesure globale. Les répondants ont été évalués en fonction de trois degrés de solitude ou d'isolement : faible, moyen et élevé, et des modèles statistiques de la solitude et de l'isolement social ont ensuite été développés. Durant l'étude, on a noté que certains répondants ne présentaient aucun signe d'isolement social ni de solitude, tandis que chez d'autres le degré variait. Dans ce mémoire, on a étudié les données recueillies pour identifier les facteurs qui influent sur le degré d'isolement social et de solitude. On a comparé les mesures tirées de ces deux variables à certains items des mesures globales et d'autres variables identifiables ayant un rôle. Le mémoire examine les variables de changement qui influent le plus sur le degré d'isolement et de solitude et produisent des combinaisons différentes. On y discute aussi des retombées sur le plan des politiques et de la pratique.

ABSTRACT

The Bangor Longitudinal Study of Ageing (BLSA), conducted in rural Wales from 1979 to 1999, followed a cohort of survivors from more than 500 people over 20 years. Using both quantitative and qualitative data from the study, the factors associated with increases and decreases in loneliness and social isolation were identified. The study was based on a population sample and survivors were followed up every 4 years. From 1983 to 1987, 30 people aged 75 and over in 1979 were studied intensively. The customary measure of loneliness was used, as well as an aggregate measure devised by the research team. Social isolation was similarly measured, using an aggregate measure. Respondents were assessed as demonstrating low, moderate, or high levels of loneliness or isolation. Subsequently, statistical models of loneliness and social isolation were developed. Some respondents were assessed as not experiencing social isolation or loneliness during the study. Others showed changes in levels. In this article, the data are explored, seeking factors associated with changes in social isolation and loneliness. Outcome measures of these two variables of interest are compared with items from the aggregate measures and other identifiable intervening variables. The article discusses which change variables contribute most to levels of isolation and loneliness and result in different combinations of these two outcomes. Implications for policy and practice are discussed.

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Introduction

The Bangor Longitudinal Study of Ageing (BLSA)¹ commenced in 1979, to ascertain the overall situation of people aged 65 and over living in rural Wales. The main focus of the study was the availability and use of informal support and formal services. Two of the outcome measures adopted were social isolation and loneliness. Being alone in old age has been perceived as a problem for many years (Forbes, 1990). In this article we seek to move towards further understanding of how levels of social isolation and loneliness may change or remain stable over time and of what factors appear to be responsible for change.

In 1979, when the longitudinal study began, the study of social isolation and loneliness was far less developed than it is today. In much of the literature neither was well defined (Wenger, 1984), and the concepts *living alone*, *loneliness*, and *social isolation* were often used interchangeably (Townsend, 1968). Most general studies used only a basic self-assessment question, asking respondents whether or not they felt lonely (*never, rarely, sometimes, often, all the time*) (Sheldon, 1948; Shanas, 1968; Weiss, 1973; Karn, 1977; Kivett, 1979). In some early studies social isolation was assumed if the older person lived alone (Tunstall, 1966; Shanas, 1968). We knew that stigma was associated with loneliness (Weiss, 1973) and that responses to the self-assessment question might, therefore, reflect a more positive situation than was in fact the case. In the BLSA study, social isolation and loneliness were, therefore, measured on the basis of aggregate measures (discussed in more detail below). The self-assessed loneliness question was also included for purposes of comparison.

The concepts of loneliness and social isolation, as used in this longitudinal study, are as follows. Loneliness is seen as a subjective measure of unwelcome feelings or perceptions on the part of the respondent, associated with a lack of contact with others or with a particular other, as a result, for example, of bereavement or geographical separation. It is associated with an unsatisfactory level of communication and closeness with others. More recently, loneliness has been described as a measure of the state of mind of a person and of their negative feelings about their level of social contact (Weeks, 1994). Social isolation, on the other hand, is defined as a more objective concept, based on the absence of contact with other people, an absence that can be quantified, and on integration with other members of society. It is the opposite of good social support (de Jong Gierveld, 1998).

Different patterns of isolation have been identified, which include those who have been lifelong isolates and those who have become isolated in old age (Ben-

nett, 1980; Wenger, 1992). Lifelong isolates tend to be men, who describe themselves as loners with lifestyles described as marginal; they may drink a lot (Bennett, 1980). Those who become isolates in old age are more likely to have become constrained in terms of social activity as a result of caring for an ailing spouse or suffering restricted mobility or dementia (Bennett, 1980). Social isolation can be experienced by individuals in four typical ways: (a) in comparison with their contemporaries, (b) in comparison with younger people, (c) in comparison with themselves at a younger age, or (d) in comparison with earlier generations of older people (Townsend, 1973). Townsend (1957) identified 3 per cent of those over 65 as being extremely isolated and 29 per cent as partly isolated. Using the composite measure at baseline of the Bangor study (discussed below), 6 per cent were assessed as being very socially isolated and 34 per cent as moderately isolated (Wenger, 1984).

The prevalence of social isolation (Peters & Kaiser, 1985; Freeman, 1988) and loneliness (Harris & Assoc., 1974) has long been thought to be over-estimated among older people. Old age has been thought of as a time of life characterized by loneliness (Jerrome et al., 1984). The highest rate of loneliness recorded in research on older people in Britain is 16 per cent (Bowling, Farquar, & Browne, 1991). At baseline of the study discussed in this article, 76 per cent stated that they were never or rarely lonely, 19 per cent said they were sometimes lonely, and 5 per cent said that they were lonely often or all the time. Using the composite measure, loneliness was assessed as low for 63 per cent, moderate for 29 per cent, and high for 9 per cent (Wenger, 1984). In other words, more loneliness appeared to be measured by the composite measure than by the self-admission variable. More recently, it was reported that 2 to 13 per cent of older people in the U.K. report that they are very lonely or often lonely (mean 10%, median 5–6%) and noted that these levels are lower than those recorded for younger people and lower than reported rates from other parts of Europe (Walker & Maltby, 1997).

The scores on both the composite isolation and loneliness measures were comparable. However, some people may be isolated but not lonely, others both isolated and lonely, and so on (Townsend & Tunstall, 1973; Wenger, 1983; Wenger, Davies, Shahtahmasebi, & Scott, 1996). Despite the absence of a direct link between isolation and loneliness (Wenger, 1983, 1984), many of the same factors have been found to be associated with both. These include living alone, never being married, widowhood, advanced age, and poor health (Revenson & Johnson, 1984; Wenger et al., 1996). Those most at risk of loneliness at baseline of the BLSA study were widowed men, married women,

very old retirement migrants, and those in poor health. Those most at risk of social isolation were never married men, the oldest old, those living alone, and those in poor health (Wenger, 1984).

As noted above, in comparing self-assessed loneliness with the loneliness measure in the BLSA at baseline of the longitudinal study (Wenger, 1983), it was found that the aggregate measure identified higher levels of loneliness than did self-assessment. The self-assessment measure appeared to under-represent those who, on the basis of observable data, had no obvious reason to be lonely and might therefore not want to admit to loneliness. For instance, the discrepancies were greatest for those who were married, lived with adult children, or had retired to the seaside or country from elsewhere – and might therefore have sought not to admit to loneliness. It was felt, therefore, that the aggregate measure had succeeded in overcoming tendencies to deny loneliness and avoid stigma.

Subsequently, statistical models of social isolation and loneliness were developed, based on correlates reported in the literature (Wenger et al., 1996). When all variables were controlled for, some of the associations noted in earlier publications (see earlier) dropped out as a reflection of co-linearity. The refined statistical model for social isolation included being widowed or never having married, length of widowhood, working-class status, and support-network type (i.e., household focused or private restricted). The resulting model for loneliness, based on the aggregate measure, included living alone, support-network type (i.e., dependent on family, household focused, or private restricted) and ethnicity (i.e., being English rather than Welsh, an incomer status). All other correlates which had been identified by other authors and which were present in the BLSA data, such as advanced age, health status, and so forth, were not statistically significant when other variables were controlled for (Wenger et al., 1996).

In this article data on the 20-year survivors of the longitudinal study, last followed up in 1999, are analysed. The stability or change over time in levels of recorded loneliness and social isolation are discussed and the changing situations of the respondents are examined to try to identify factors associated with increased or decreased levels of loneliness. The relationship between advanced age and loneliness has been identified. This study focuses only on the oldest old, aged 85 to 102; as noted earlier, however, advanced age dropped out of the statistical model, reflecting co-linearity with widowhood, declining health, and other losses.

Methods

The study was based on a population sample (1979) and survivors were followed up every 4 years, with five measurement points (1983, 1987, 1991, 1995, 1999). Respondents were interviewed in the language of their choice; that is, Welsh or English. Interviews took place in the homes of the respondents, using an administered survey schedule, which included open-ended questions. Qualitative data from open-ended questions and verbatim comments were also recorded. The interviewers were also required to write a short report describing the overall situation of the older person. They were asked to describe their general impression of the respondent – in terms of health, morale, needs, and problems – and to write two to three paragraphs giving a résumé of the respondent's overall current situation. In 1995 and 1999 the authors conducted a substantial proportion of the interviews themselves.

Measures

Aggregate measures of social isolation and loneliness were based on the distinction between objective (isolation) and subjective (loneliness) responses, as discussed earlier. Social isolation was measured using eight questions on a series of contributing factors to social isolation (contact with others and constraints on contact). The word *isolation* was not used. Loneliness was measured using eight questions based on feelings or attitudes to levels of social contact, all but one not using the word *loneliness*. These sets of questions were dispersed throughout the interview schedule. The customary measure of loneliness was also included in the survey so that we could compare our data with findings from other studies. This has been discussed elsewhere (Wenger, 1983).

Respondents were classed as demonstrating low, moderate, or high levels of loneliness or isolation based on relative scores. For social isolation, respondents were deemed to be *not isolated* if they scored 0 to 1, *moderately isolated* at 2 to 3, and *very isolated* if they scored 4 or more. Respondents were deemed to be *not lonely* if they scored 0, *moderately lonely* at 1 to 2, and *very lonely* if they scored 3 or more. The reason for the difference in the ways isolation and loneliness were classified numerically was that individual indicators of isolation were not considered sufficient to justify classifying the respondent as isolated; for instance, living alone or not having a telephone was not considered sufficient, on its own, to indicate isolation. The modal scores at baseline were 1 for social isolation and 0 for loneliness and the distributions of both were skewed towards not being lonely or isolated. The items for both measures are shown below.

Items used as indicators of social isolation:

- lives alone
- has no close relatives
- never visits anyone
- has no contact with neighbours
- has no telephone
- is alone for more than nine hours a day
- nearest neighbour more than 50 yards away (out of earshot)
- never goes out of the house

Items used as indicators of loneliness:

- feels lonely much of the time
- does not see enough of friends and relatives
- does not meet enough people
- has no confidant
- wishes for more friends
- has no one of whom to ask favours
- has no real friends living nearby
- spent the previous Christmas alone and lonely

One of the difficulties with longitudinal studies is that in order to maintain comparisons throughout the study, the same measurements need to be used. If we were designing the scales now, no doubt we would come up with something more sophisticated. These were crude aggregate measures, with eight items each and scores based on the number of isolated or lonely responses. In these scales, for instance, all indicators were equally weighted.

Deciding which questions to ask was based on an understanding of the literature existing in 1978. One reviewer of this article suggested that a question asking whether the respondent was visited by other people (to balance the question asking respondents whether they visited anyone) should have been included in the isolation scale. The decision as to which questions to include was made to determine how long people were alone at home during the day and whether they were able to ameliorate long hours alone by visiting others. The number of possible inclusions will always exceed the number of items included.

Data for all items in the aggregate measures are available for 1979, 1987, and 1995. Additional qualitative data for each survivor are available at all measurement points. In this article, aggregate measures are compared for the three measurement points for which they are available and trends over time are identified. It is, of course, less than satisfactory to be comparing data at 8-year intervals. In assessing possible change

factors, therefore, the quantitative data is supplemented, on a case-by-case basis, by additional qualitative data from the files for all measurement points.

Characteristics of the 1999 Sample

By 1999 there were only 63 survivors (from the original population sample of 534 aged 65 or more). They ranged in age from 85 to 102. The average age in 1999 was 93 (for both those living in the community and those in long-term care) and the sample included 3 centenarians. There were 16 survivors who were in long-term care. The loneliness and social-isolation measures were developed for use with older persons living in the community. In this article, therefore, we focus on those 47 survivors who were still living independently in 1999. The sample, therefore, includes 47 people aged 85 to 102, with an average age of 93. Fifteen were men (7 married, 6 widowed, and 2 who had never married) and 32 were women (3 married, 22 widowed, and 7 who had never married).

All those who were married (10) lived with their spouse only. One single woman lived with her sister. All the other people who had never married lived alone. Most of those who were widowed (28) lived alone (23). One widowed woman lived in a three-generation household in the farmhouse she moved to when she was married in 1931. Another widow, aged 102, lived with two unmarried sons on the farm she had moved to on marriage in 1924. Another widow lived with a divorced son, who had returned home with his daughter when his marriage broke down. One widowed man had moved in with his youngest son and daughter-in-law when his wife had entered a dementia-care home; another had lived with his youngest daughter and son-in-law since his wife died.

Findings

At baseline, findings for the total sample ($N = 534$) indicated that most respondents were not socially isolated (60%) or lonely (63%). Small proportions were very isolated (6%) or very lonely (9%), a third (34%) were moderately isolated, and almost a third (29%) were moderately lonely. The 1979 findings for the 1999 survivors at baseline were comparable with findings for the whole baseline sample (see Tables 1 and 2).

Social Isolation and Loneliness over Time

Table 1 shows the social-isolation scores for the 1999 survivors living in the community, comparing 1979, 1987, and 1995. The proportions of those who were very isolated were small, but moderate isolation increased with advancing age. By 1995 nearly three-fifths (59%) were at least moderately isolated.

Table 1: Social isolation among 1999 survivors in the community: Comparing 1979, 1987, and 1995 (N = 47)

Aggregate Isolation Measure (IM)	1979 (Age 65+) (%)	1987 (Age 73+) (%)	1995 (Age 81+) (%)
Not Isolated	64	60	36
Moderately Isolated	28	26	55
Very Isolated	6	6	4
Missing	2	9	4
Total	100	100	100

Columns may not total to 100% due to rounding.

Table 2: Loneliness among 1999 survivors in the community: Comparing 1979, 1987, and 1995 (N = 47)

Aggregate Loneliness Measure (LM)	1979 (Age 65+) (%)	1987 (Age 73+) (%)	1995 (Age 81+) (%)
Not Lonely	64	57	38
Moderately Lonely	23	28	47
Very Lonely	9	6	9
Missing	4	9	9
Total	100	100	100

Columns may not total to 100% due to rounding.

Table 2 compares levels of loneliness among the survivors in 1979, 1987, and 1995. The proportions of those who were assessed as very lonely were low at all measurement points. However, as with social isolation, the prevalence of moderate loneliness increased with advancing age, and by 1995 more than half (56%) were assessed as at least moderately lonely.

It is possible to look at individual patterns of social isolation and loneliness levels at the three measurement points from 1979 to 1995. Despite the fact that

the prevalence of both social isolation and loneliness increased over time, significant minorities of survivors were neither isolated nor lonely at any measurement point, and others became less isolated or less lonely over the course of the study. Still others exhibited fluctuating patterns. Since small proportions were identified as *very* isolated or *very* lonely at any point, *moderately* and *very* isolated or lonely categories have been aggregated into *socially isolated* and *lonely* in this discussion.

Table 3: Patterns of social isolation and loneliness: 1979, 1987, and 1995 (N = 47)

	Isolated		Lonely	
	%	(n)	%	(n)
Measurement Complete				
Not Stable at Any Point	26	(12)	26	(12)
Stable at Every Point	17	(8)	15	(6)
Overcame	2	(1)	6	(3)
Fluctuated	15	(7)	9	(4)
Became	28	(13)	26	(12)
One Measure Missing				
Not Stable at Either Point	4	(3)	6	(4)
Stable at Both Points	2	(1)	4	(2)
Overcame	2	(1)	2	(1)
Became	2	(1)	6	(3)

Given the long period of 8 years between the measurement points at which the composite measures were used, it is likely that there were other fluctuations that were not recorded. However, by examination of the full file of qualitative and quantitative data for particular cases, it is possible to identify changes in situations that were reflected in changes in levels of social isolation and/or loneliness. The patterns of social isolation and loneliness are shown in Table 3.

One of the pitfalls of longitudinal studies is the difficulty in collecting all data at all measurement points for all respondents, particularly where aggregate measures are concerned. For 6 (13%) of the survivors in the community, one isolation measure was missing and for 10 (21%) one loneliness measure was missing. We have, however, indicated the types of stability/change that could be observed from the two remaining measures. The missing measures were fewer for isolation because this was based on objective variables, which did not involve feelings and could be ascertained – through the use of proxies, for instance – without respondents' refusing to say or having to give information themselves.

Neither social isolation nor loneliness are stable measures. For approximately half of the survivors, change occurred over the course of the study. The dominant patterns were for respondents to have become isolated and/or lonely over time or to have been assessed as not isolated and/or lonely at each measurement point. A few were isolated and/or lonely at each measurement point. Others fluctuated between isolated and not isolated or between lonely and not lonely. A few overcame isolation or loneliness between measurement points.

The distributions in Table 3 give the impression that isolation and loneliness were correlated fairly closely; however, this was not the case (Wenger, 1983). In 1999, eighteen different combinations of values occurred, but many of them were idiosyncratic. The three most common combinations were as follows: respondents who became more isolated *and* lonelier over the course of the study ($N = 8$), respondents who were neither isolated nor lonely at any measurement point ($N = 6$), and respondents who were never isolated but became lonely ($N = 5$). Of those 12 who were identified as not isolated at any measurement point, only 6 were also not lonely. Of 7 who were always isolated, only 2 were always lonely. Of 14 who became more isolated over time, only 8 became lonelier.

In order to try to identify what influences were likely to affect social-isolation and loneliness levels, the files of all respondents were examined. It is perhaps relevant to re-emphasize at this point that, by the end of the study, the average age of respondents was 93 and

the majority were living alone. The following analyses are based on small numbers and must be seen as raising hypotheses rather than building theory.

The most common items of the measurement scales which contributed to isolation or loneliness, in order of prevalence, were as follows: (a) for isolation – living alone, being alone at home for more than 9 hours a day, having no telephone, and living 50 yards away from the nearest neighbour (out of earshot); and (b) for loneliness – having no real friends nearby, wishing for more friends, feeling lonely much of the time, and not seeing enough of friends and relatives. Interestingly, all of the isolation items refer to spatial isolation rather than to a lack of contact with others, although the latter was clearly affected by the former.

All of the items in the two scales contributed to the scores of at least some survivors, with the exception of being alone and lonely over Christmas. However, some said that they had spent Christmas alone “by choice.” Although not adding to the loneliness measure, this may be seen as a *post hoc* evaluation. Similarly, some said *not* that they had no one to ask favours of but that they never asked favours of others. Again, this did not add to the loneliness measure but could be seen as indicating a feeling that there was no one to ask.

Neither Isolated nor Lonely (N = 6)

Those who were neither isolated nor lonely over the course of the study were married throughout. None of them lived alone. Most were married men. Most had adult children living nearby. All had lived in the same local area for decades and most were involved in farming. Most had locally integrated support networks, made up of family, friends, and neighbours and including community involvement, which became family dependent in the face of failing health.

Case History 1

Case 335 was a farmer who was born in 1905. He was married and had always lived in the same community. He had a son and a daughter. His daughter lived nearby. In 1979 he and his wife had recently retired to a new house in the small town where they had always lived. He had given up driving by 1987. By 1995 he was confined to a wheelchair with Parkinson's disease and they had moved into sheltered housing in the same town. He no longer attended chapel or other meetings but he could get outside and enjoyed chatting with his friends. He was proud of his new great-grandchild. A home-care worker came daily to get him up in the morning and to put him to bed in the evening and she was still coming in 1999. By then his speech was affected by the Parkinson's. He was 94 and his wife was 93. She did not want him bothered by an interview, but he insisted, despite

the difficulties he had with speech. Friends visited him at least once a week. His daughter came in daily, his wife was in good health, and he was neither isolated nor lonely.

More Isolated and More Lonely with Increasing Age (N = 8)

The most common category was those who became more isolated and lonelier over the course of the study. The main isolating factor was being alone at home during the day for increasingly long periods. This was often associated with becoming housebound, losing close touch with neighbours, and/or not visiting people. Over time most in this sub-group reported that they felt lonely much of the time, no longer had real friends nearby, did not meet enough people, and/or did not see enough of friends and relatives. Although the responses did not add to loneliness scores, a few also reported that they no longer asked people to do favours or that they had spent Christmas alone "by choice." Most of these respondents also had locally integrated support networks, made up of family, friends, and neighbours, and, at least early in the study, were involved in community activities that were subsequently given up.

It is difficult to disentangle factors that contribute to either isolation or loneliness because they tend to overlap. Other factors associated with becoming more isolated and lonelier over time were being widowed; experiencing deteriorating health or impaired mobility, vision, or hearing; and experiencing the death or other loss of relatives, friends, and/or close neighbours. Overall, it would appear that there were clear parallels in the factors contributing to isolation and to loneliness here. Increasing loneliness, for many, reflects increasing social isolation.

Case History 2

Case 161 was a woman born in 1903. She and her husband had two sons, who lived at least 30 miles away. They lived in a cottage on the road between two villages, with only a farm across the road as neighbours. In 1979 they were both mobile and in good health. In 1983 she reported that her best friend and another friend from the nearby village had both died, and she was missing them both. By 1987 she was living alone; her husband was in hospital suffering from dementia and died the following year. Both her sons suggested she go and live with them, but she was determined to remain where she was. She had a home help who had been coming since her husband was ill, and her husband's former boss took her to church or to hospital appointments. Her sons helped her with gardening and household repairs when they visited. She was suffering from angina and high blood pressure. Her neighbour from across the road popped in from time to time.

By 1995, at 92, she was dependent on her home help, who came daily. This woman came first thing in the morning to make her a cup of tea and to see that she was all right, did all the housework, collected her pension, and had become her friend and confidant. She had a commode in the bedroom. In 1999 she was still at home and still had the same home help, who now made food for her as well, and her neighbour came across to see her every evening. She was not able to do much for herself and worried about a daughter-in-law who had cancer. Her husband's boss had entered a nursing home. In 1979 she was neither lonely nor isolated; by 1999 she was both moderately isolated and moderately lonely.

Not Isolated but Lonely (N = 5)

In order to try to identify factors contributing to either isolation or loneliness, we need to look at those who were *never* isolated but were lonely at some point during the study. For example, one married man, living in the community in which he had spent his entire life, was never isolated and was identified as lonely at only one measurement point. The interview took place shortly after a close friend had moved away. He had recovered by the next measurement point.

Most of those who were not isolated but were lonely during the study were only moderately lonely. The most prevalent factor associated with this situation was deterioration in health (including impaired mobility, cognitive function, or sight or hearing, and falls). Others were widowed, caring for a dependent spouse, or living with an adult child who worked full time. Some were retirement migrants (not Welsh) or moved to a different community during the study. A few reported receiving few visitors or getting no help with caring responsibilities. By 1999 a few of these had become moderately isolated. These respondents tended to have either wider, community-focused support networks, focused on friends and voluntary organizations, or family-dependent support networks.

Case History 3

Case 305 was a woman born in 1910, who was not isolated but became moderately lonely during the study. In 1979 she was a very contented farmer's wife and had been married for 42 years. They had a son and a daughter. She said that they were friendly with the neighbours but did not name any real friends. Their nearest neighbour was more than 100 yards away. In 1986 her husband had a stroke just before Christmas. Her daughter came to help, but subsequently, on a day-to-day basis, her contact with her children was limited. Her own health was also deteriorating. As her husband recovered, she relied on him more again, but by 1995 he was housebound and dependent on her care. She found caring for

him physically demanding and she got no help. They had spent the previous Christmas alone. She went over to her son's farm every day to visit briefly. She saw her only surviving sister every week and confided in her and was still doing this in 1999.

Isolated but Not Lonely

In contrast, those in another group were isolated throughout the study but were either not lonely at any point or overcame loneliness during the course of the study. Some reported spending Christmas alone by "choice". All were childless and most were very isolated at most measurement points. Several were identified as having quiet, retiring, or reserved personalities and either as "keeping themselves to themselves" or "enjoying their own company". At the same time, they were also described as cheerful or pleasant. Because of the small numbers involved, it is not possible to make confident comments, but those who overcame loneliness during the study seemed either to have satisfying relationships with friends and/or neighbours or to be lifelong isolates. Often the latter were described as lonely by interviewers, and the possibility of denial should be considered. These respondents tended to have household-focused, local, self-contained support networks, relying primarily on neighbours; or wider, community-focused networks, based on friends and voluntary organizations; both of which types of networks tended to become private restricted over time.

Case History 4

Case 564 was a man born in 1911. He had been a gardener all his life and was still working one day a week in 1979. He had been one of nine children and had three living siblings – two brothers and a sister. He saw his sister more than once a week and listed his sisters-in-law as friends. He had been widowed in 1977 when his wife died of cancer. He commented on how much he missed her. He had good neighbours, one of whom cooked him a hot meal every day for a while after his wife died. He was still missing his wife in 1987. One of his brothers had died and he now only saw his sister once a week. He had one son and had lost two other children. He saw his son about every month. He was still working and had good friends and neighbours. Little changed over the ensuing years. He was still working in 1995, at age 84. By 1999 his son was living within a mile and he saw him once or twice a week, but his sister had died. He saw friends daily but had lost his good neighbours and said that he was the only Welsh person on his street. He was assessed as moderately isolated on the basis of living alone, spending many hours alone every day, and living in a house that was between 50 and 100

yards away from its nearest neighbour; but he was never lonely.

Overcoming Loneliness or Isolation

Four people were less lonely at the end of the study than they had been before and four others fluctuated between being lonely and not being lonely. One woman, who had been widowed 10 months before the start of the study, was lonely in 1979. By 1991 she reported two or three very good friends and good neighbours and was no longer lonely. An example of possible denial of loneliness was the case of a retired gamekeeper, who had never married and had led a very isolated life and who became more and more isolated over the course of the study. In 1979 he had admitted that he felt lonely much of the time and that he did not see enough of friends or relatives. At each measurement point he said he had spent Christmas alone "by choice." At subsequent interviews, on the basis of the quantitative data, he was recorded as not lonely, although his health had deteriorated. The interviewers' reports, however, regularly recorded that he seemed to be very lonely and depressed, although by 1999, at age 92, he seemed "more cheerful"; he seemed resigned to his solitary existence.

About half of those who were isolated but overcame loneliness had made major changes in their lives during the study. For example, a widowed farmer who was isolated and very lonely in 1979 had a heart attack and immediately moderated his workload by cutting down on his livestock. He nominated a nephew as his heir, who then came to work on the farm. He put in central heating and double glazing. He had more time to chat with neighbours and went to the pub most evenings. Consequently, he was no longer lonely. Similarly, a single man, who in 1979 was lonely and living alone after the death of his sister, moved from an outlying hamlet into sheltered housing in the nearby market town. He had more company and had weekly contact with another sister who lived nearby. A friend visited daily. By 1999, although very disabled and in a wheelchair, he spent time with others in the sheltered housing complex every day, was bright and alert, and had high morale.

There were few cases of respondents who were isolated at some measurement points and subsequently not isolated and two cases, only, who overcame isolation over the course of the study. One was a childless woman, with no living relatives, who had been widowed in 1977 and remarried during the course of the study. The other was also a childless woman, with no living relatives, who had been widowed in 1978. When interviewed in 1979, she spent a lot of her time alone, never visited anyone, and said she had no living relatives. She was a very independent woman and refused to be interviewed in 1987. She was described

by the interviewer in 1991 as “keeping herself to herself” and in 1995 as having a meagre network. However, by 1999, at age 92, she had a private home-care worker who came every day and looked after her, took her out in the car, and had become a good friend. She also had good relationships with two or three of her neighbours.

Discussion

It is uncommon to have data for the same individuals over the course of 20 years. Although the 1999 sample of older people living in the community was small, it has made a contribution to our understanding by enabling us to look at social isolation and loneliness over time, showing that these conditions are not static and are amenable to amelioration. It has also been possible to show how events in the lives of older people contribute to an increase or decrease in levels of social isolation and loneliness.

The findings presented in this article have some limitations. They were based on small numbers of survivors who were studied over time and, as in most longitudinal studies, missing some measures at some measurement points was unavoidable, due to the absence or illness of respondents. In this case, although respondents were traced and re-interviewed every 4 years, the loneliness and social-isolation measures were collected only every 8 years. It is recognized that other changes in the variables of interest could have occurred between measurement points.

Assessments of social isolation and loneliness were based on aggregate measures of items measuring, respectively, the objective and subjective aspects of being alone. Over the course of the study, fewer than half of the measures for each outcome variable remained stable. For the majority, therefore, levels of social isolation and/or loneliness changed in the

course of the study. Combined patterns of the measures for both variables were highly idiosyncratic, although three predominant patterns were identified.

Table 4 summarizes the major contributing factors in the four most prevalent situations encountered in the data. Only two cases were identified in which the respondents had been consistently isolated and lonely throughout the study, and this situation is omitted from the table. In most instances, each respondent was characterized by only one or two of the factors listed in the table, but all the factors listed recurred for those with that pattern of isolation and loneliness. The findings suggest a number of hypotheses:

- Recent widowhood creates a risk of loneliness and the risk of isolation increases with increasing length of widowhood.
- Retirement migration or moves to other communities after retirement age appear to increase the risk of loneliness, even in the absence of isolation.
- Deterioration in health, mobility, vision, or hearing creates a risk of loneliness.
- Caring for a dependent spouse (especially without help) creates a risk of loneliness, even in the absence of isolation.
- Childlessness creates a risk of isolation, but not necessarily loneliness.
- Living near adult children protects against isolation and loneliness.
- Living in an adult child’s household may predispose to loneliness.
- Deaths of relatives, friends, and close neighbours increase the risk of loneliness and, to a lesser extent, isolation.
- Lifestyle changes can protect against or relieve loneliness, even in the face of isolation.
- Self-sufficient personality may predispose to isolation.

Table 4: Major contributing factors in four patterns of isolation and loneliness, 1979–1999^a

Not isolated / Not lonely at any time

Indigenous to area

Long-term residence in community

Involvement in farming

Married

Not living alone

Adult children living nearby

Became more isolated and more lonely over time

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

Table 4 continued

At home alone for increasingly long periods during the day

Not isolated but lonely

Retirement migrant or moved during study

Widowed

Caring for dependent spouse with little help

Living with adult child working full time

No one visits

Death or other loss of friends

Deterioration in health

Tendency not to ask for help

Isolated but not lonely/overcame loneliness

Childless

Self-sufficient personality

EITHER satisfying relationships with friends/neighbours

OR lifelong isolates

Spend Christmas alone by choice

Lifestyle changes

a Always isolated/always lonely – not enough cases

In order to identify which change variables were associated with shifts in levels of social isolation and loneliness, quantitative and qualitative data in the files of respondents still living in the community were examined. The characteristics of those who were neither socially isolated nor lonely at any measurement point suggest factors that protect against isolation and loneliness: Stability seems to be key. By the same token, by looking at factors associated with cases where social isolation and loneliness both increased over time, we can identify situations where increasing isolation is associated with increasing loneliness: Loss seems to be key. Neither of these situations, however, makes it possible to identify which change factors are associated specifically with either isolation or loneliness. However, by looking at cases where respondents were consistently lonely despite not being isolated, we can raise hypotheses about factors, other than isolation, which contribute to loneliness: Again, loss seems to be key. Conversely, by looking at cases where respondents were consistently isolated but were not lonely or overcame loneliness in the course of the study, we can raise hypotheses about factors that protect against loneliness in the context of isolation: Relationships with non-kin seem to be key. We can also suggest hypotheses about factors associated with isolation: Childlessness and independence seem to be key.

Patterns of social isolation and loneliness are complex (de Jong Gierveld, 1998). Many of the contributory factors are beyond the control of the individual; for example, widowhood and other deaths, failing sight/hearing/mobility/health, and becoming responsible

for the care of a dependent spouse. Other risk factors have at least some element of choice or control associated with them, such as moving to a different community after age 60, moving in with children, or not being prepared to ask for help. Conscious decisions to change lifestyle can be effective in combating loneliness and isolation.

Indicators for Practice and Policy

It was noted in the introduction to this article that the fastest-growing age group in the developed nations is the over-85 group. Social isolation has attracted the interest of gerontologists and practitioners in the field of elder care because of its obvious relationship with the availability of help in the face of the health and mobility problems associated with advancing age. It has also been noted that, while there is no equivalence between isolation and loneliness, both increase with age. The proportion of those living alone is increasing generally, particularly among older people.

As the findings presented in this article show, loneliness can exist in the absence of social isolation. It has also been found that feelings of loneliness may be associated with the receipt of help (Burholt & Wenger, 1999; McCamish-Svensson, Samuelsson, Svensson, & Dehlin, 1999), which suggests that instrumental interventions may need to be provided in the context of emotional support.

- Older people living with their children are among the loneliest (Wenger, 1983) and are more likely to suffer from depression (Dunham, 1995). This suggests that

interventions that link lonely older people with others outside the household may be particularly helpful.

- Widowhood can lead to devastating loneliness, depression, apathy, and lethargy, severe enough that medical intervention may be needed (Jerrome et al., 1984). This indicates an unrecognized need for bereavement support and highlights the importance of practitioner awareness of the relationship between emotional stress and health.
- Many women have been shown to be lonely as a direct result of a lack of good mental or physical health (Jerrome et al., 1984). This shows the importance of emotional support in the context of poor health.
- Both isolation and loneliness have been shown to be associated with poor physical health and with less positive outcomes following surgery, depression, and other forms of mental illness (Wenger et al., 1996). Again the need for emotional support is indicated.
- Systems for identifying older people in need of support can be developed with information from doctors and others to whom isolated or lonely people may turn or be directed, so that emotional support can be offered and can be considered by those potentially at risk.
- To keep pace with the needs of the increasing proportion and number of older people, particularly those in the 85-and-over age group, and to help them avoid the health effects of loneliness and social isolation, practitioner monitoring is important.
- Some aspects of isolation can be avoided or ameliorated by timely interventions.
- Personal access to a telephone is important.
- Attendance at a day centre or voluntary group works for some but can exacerbate feelings of loneliness and social isolation for others.
- Services that aim to support isolated older people are often not what isolated older people want.
- Rehabilitation and physiotherapy to maintain mobility enhance opportunities for getting out and being with others.
- Support for spouse caregivers can alleviate loneliness and have a long-term protective effect against deterioration in the health of the caregiver.
- Sitting services for caregivers can reduce social isolation by making it possible for caregivers to get out of the home and spend time with friends or relatives.
- Teaching coping skills for those with sensory impairments can protect against isolation and loneliness and prolong independence. This aspect of coping should be included in domestic activities.
- Age discrimination in public policy and practice has been identified as a source of loneliness (Simey, 2002) and does not appear to be included in anti-discrimination training. Specifically focusing on age discrimination in training could improve the situation.
- Often social isolation is due to barriers that can easily be overcome (for example, a sticking door or the lack of a wheelchair).
- Unfortunately, lonely older people are being offered membership in inappropriate groups; they are very sensitive to rejection, sometimes imagined, and are reluctant to put themselves forward or to ask for help.

Service providers find social isolation and loneliness two of the most difficult problems to work with, despite having high levels of empathy for their clients (Russell, 1999). Many older people experiencing loneliness or isolation are unwilling to talk about it because such an acknowledgement challenges their identity as independent people (Russell, 1999). By the same token, some isolated older people may not welcome intervention identified as tackling loneliness or social isolation because of the stigma involved (Russell, 1999). However, group interventions work for some people, and the research literature reports some interesting findings in this respect.

- Lonely people have been found to benefit more from groups designed to meet some other need, such as housing, rather than loneliness (Stevens, 2001).
- Services designed to support isolated older people are not always the sort of thing that older people want.
- Group interventions should be targeted at those who are ill, poor, depressed, or suffering other mental health problems, including dementia, or who have heavy caring responsibilities.
- A friendship-enrichment program organized in the Netherlands, stressing self-esteem and goals related to friendship and based on 12 structured group sessions, was successful in attracting lonely older women and in reducing loneliness, a reduction that was sustained in the year following the program (Stevens, 2001).
- Structured interventions can have positive results but not all interventions are successful and they need to be well designed, taking account of findings from the literature.
- People should be *approached* at times when they are more likely to need help: for example, after bereavement, coming out of hospital, or moving house.

Creative ways of disseminating information should be sought, such as through services for older people that provide such things as household repairs, gardening, hairdressing, or home care (Cattan, 2001).

Professionals' work is constrained in two main ways: (a) by *inadequate resource allocation*, which limits the time that can be spent with such clients; and (b) by the fact that *emotional care is often not seen as part of the service* (Russell and Schofield, 1999). In these ways the structure of organizations negatively affects the relationships between clients and professionals and the outcomes of care. Practitioners have been found to be

conservative in the ways they target and identify isolated older people. Changes in patterns of contact with service providers or seeking medical treatment or service provision may be an indication of a need for emotional support.

A Help the Aged (U.K.) study looked at what older people want in terms of service provision (2002).

- They want to be involved in planning and developing activities.
- They want low-level help that enables them to maintain independence but helps them to gain confidence and find their own solutions.
- They want solutions tailored to their particular needs.
- They want transport suited to their particular mobility problems.
- They want services that cater for particular categories, such as caregivers, members of specific ethnic minority groups, recent immigrants, older men, people with hearing and visual impairments, or those who have been isolated for a long time.
- Many of them want one-to-one support.

To conclude, 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. Loneliness can lead to mental illness and can be targeted for reduction. It is responsive to change if interventions are designed carefully and reinforce and improve social skills and self-esteem. Social isolation is often associated with loneliness, but it 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 intervention and change. Solitude may be associated with a greater risk of undiscovered emergencies, but it is probably the risk that should be reduced and not the solitude itself, which may be cherished.

Note

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