Title: Loneliness in older age: what is it, why is it happening and what should we do about it in Australia?

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Abstract
Loneliness is an important health issue facing older people due to its association with poor quality of life and poor health outcomes. This paper aims to clarify key issues around loneliness among older adults and draw attention to innovative programs and the translation of emerging research into practice.

Loneliness is a mismatch between a person’s actual and desired social connections, experienced as negative emotions. Older adults are vulnerable to loneliness because of changes associated with ageing. As such, identifying as older is often seen as a burden, negatively impacting self-esteem, sense of purpose, and relevance, culminating in loneliness.

Interventions combatting loneliness can target individuals, relationships, communities or societies. We advocate for an intersectoral approach to support healthy ageing and reduce loneliness. This will require further research to evaluate new approaches with loneliness as the primary outcome, and additional funding to translate evidence into an integrated multi-levelled approach to addressing loneliness.

Key words: Community integration, Loneliness, Ageing, Social connection
Introduction

Loneliness is emerging as one of the most important health issues facing older people, and the risk of loneliness has increased during the COVID-19 pandemic.\(^1\) Loneliness contributes to poor quality of life and is comparable with well-established risk factors for mortality such as smoking, sedentary lifestyle, and air pollution.\(^2\) But what exactly is loneliness, why is it happening, and what should we be doing about it? In this paper, we (i) provide an overview of loneliness, including prevalence in older people and impact on health and wellbeing; (ii) present explanations for the high rates within Australia’s older population; and (iii) discuss emerging innovations and translating research into practice. This paper adopts a pragmatic, knowledge translation lens and builds on current knowledge by reframing existing theory and discusses how it is being applied in practice.

What is loneliness?

Loneliness refers to subjective feelings of a perceived lack, or loss, of companionship and social connection.\(^3\) It is a mismatch between a person’s actual social connections and their desired relationships with others that is experienced as negative, uncomfortable, and emotionally distressing.\(^4\) The term loneliness is often used interchangeably or in combination with the term social isolation, which can create confusion in defining each concept and differentiating between them.\(^5\) Fundamentally, social isolation is about the quantity of social connections within a person’s social network, while loneliness is about the quality of a person’s social connections.

Social isolation is generally defined and assessed in terms of the number and frequency of social contacts, living arrangements, or community involvement.\(^5,6\) In contrast, loneliness is often defined and assessed in terms of subjective wellbeing, with emotional loneliness reflected in one’s perceptions of close, intimate relationships while social loneliness captures one’s wider sense of belonging and inclusion. Although social isolation may lead to subjective feelings of loneliness, this is not always the case.\(^7\) For example, people with few social connections or who live alone may not feel lonely. Conversely, people with extensive social networks may still feel lonely because they perceive that these relationships are not meeting their social and emotional needs. Therefore, social isolation and loneliness...
can occur independently or concurrently, however it is more often subjective feelings of loneliness that have consistently shown to impact health and wellbeing.\textsuperscript{8}

The experience of loneliness can vary over time and between individuals. Some individuals experience situational loneliness, which is more severe loneliness at certain times in the day, week, or year; or only in response to a significant life event such as relationship breakdown or bereavement.\textsuperscript{9,10} The experience of situational loneliness contrasts with chronic loneliness, which is more constant across time and settings. Situational loneliness appears to be more common than chronic loneliness, with 18\% of individuals aged $\geq$ 50 years being situationally lonely compared to 4\% being chronically lonely.\textsuperscript{11}

**Loneliness among older people**

Measurement of loneliness varies across studies; however, it is generally reported in terms of the frequency or intensity of feelings of loneliness. Differences in study design or potential sources of bias such as the measurement tool, sample size, response rate, and sample bias can lead to variation in prevalence studies.\textsuperscript{12} Recent results from a representative sample of older Australians (\(\geq\)65 years) indicate that 46\% reported feeling that they lacked companionship at least sometimes.\textsuperscript{13} Another Australian study found 32\% of older people reported feeling lonely sometimes, and 9\% reported feeling lonely often or always.\textsuperscript{14} Notably, these studies involved directly asking a person how often they feel lonely. Victor, Scambler, Bowling, Bond\textsuperscript{10} reported that when asked directly, people may withhold or underreport true experiences of loneliness, either due to social stigma or to poor understanding of the concept of loneliness itself. Therefore, the true prevalence of loneliness amongst older adults is likely to be underestimated.

The impact of loneliness on health and wellbeing is considerable, and there is growing evidence that indicates loneliness is the next public health priority.\textsuperscript{15} Loneliness is also associated with increased risk of developing multiple chronic conditions\textsuperscript{16} and poorer mental health outcomes.\textsuperscript{7} Older adults experiencing loneliness are 1.9 times more likely to experience depression, 1.2 times more likely to experience generalised anxiety, and 1.4 times more likely to report suicidal ideation than non-lonely counterparts.\textsuperscript{16} Loneliness is also associated with functional and cognitive decline in older adults, including reduced capacity to manage activities of daily living, a decline in mobility, and increased rates of cognitive deterioration\textsuperscript{18}. Specifically, loneliness is associated with 1.6 to 2.1 times greater risk of
developing dementia over 4 to 10 years, as well as greater cognitive impairment and more rapid cognitive decline.\textsuperscript{19}

Added to this, loneliness is associated with reduced engagement in health promotion behaviours and with increased likelihood of rehospitalisation.\textsuperscript{20} Among older adults, chronic loneliness is associated with an increased number of physician visits, even after accounting for the number of illnesses and subjective health.\textsuperscript{21}

\textbf{Why is it happening?}

Why people feel lonely is complicated, and while we present a summary, there are a number of comprehensive reviews provided elsewhere.\textsuperscript{22-24} Factors that may drive loneliness in older adults can be explored using the Social Ecological Model (SEM) which is a four-level framework that considers the complex interplay between individual, relationship, community and societal factors.\textsuperscript{25} Transitions in later life can make older adults particularly vulnerable to developing loneliness due to changes related to a person’s characteristics across all four levels.\textsuperscript{26} While transitions are experienced by everyone, they tend to increase and have greater impact on our life as we age. Some transitions are expected (e.g. from worker to retiree, parent to grandparent), while others are less desired (e.g. from abled to disabled). Regardless of their positive or negative consequences, all changes alter a person’s individual sense of identity, relationships with others, their sense of belonging within a community and their relevance and contribution to society.\textsuperscript{24,27}

\textbf{Individual}

Later life transitions may include changes in individual demographic, health and socio-environmental factors such as loss of mobility, cognitive decline, reduced access to resources and financial pressures.\textsuperscript{24,28} Research conducted by a peak consumer body, the Health Issues Centre, suggests that the impact of transitions occurring later in life can affect both the way that an older person views themselves, and the way society views them. In these contexts, identifying as older or being perceived by themselves and others as a burden is not uncommon.\textsuperscript{27}
Relationships

Transitions associated with changed living arrangements, separation or loss of a partner, bereavement of close friends and family or loss of a pet can impact on a person’s close relationships and reduce the number of people within one’s social network.28,30

Community

With increasing age, the role of individuals within their workplaces and in the general community changes. Social research interrogating the proposition “It isn’t easy growing old”, found that when traditional social roles of being an employee or parent become redundant, there is a negative impact on a person’s self-esteem, sense of purpose, and sense of belonging.28,30

Societal

Poor perceptions of ageing in society can create negative attitudes and discrimination towards older people, which is a form of interpersonal ageism that leads to feelings of social and emotional loneliness.29 The World Health Organisation (WHO), in its 2015 World Report on Ageing and Health, argues that ageism in society “is now a more pervasive form of discrimination than sexism or racism” (p. 11). It goes further, to say that “these negative stereotypes are so pervasive that even those who outwardly express the best of intentions may have difficulty avoiding engaging in negative actions and expressions”.29

Ageism is also apparent in our health policies, system and institutions.29 Healthcare that is primarily structured and funded to address one-off short-term health issues, often prioritises physical concerns that are more common in younger people. Further, there is an embedded rationing of treatments for individuals over a certain age, implying that the resources should be spent on those predicted to have a longer life. 31 Negative attitudes towards ageing are perpetuated among health professions. For example, older people can be called ‘bed-blockers’, implying that they are preventing others, who are more worthy, to occupy these beds.32 In addition, ageism affects the openness with which new approaches are applied to improve the health and wellbeing of older people. For example, there is a false assumption by the general community and digital technology industry that older people are unable to use technology; and yet ≥65 year-olds are the fastest growing group of user.33
What should we do about it?

Given the plethora of problems that loneliness creates, it is unsurprising that several approaches to reducing loneliness have been trialled, generally focusing on one discrete intervention to meet the needs of all targeted individuals. Existing interventions can be broadly grouped according to the four levels of the SEM. Figure 1 presents interventions and solutions to loneliness at each level.

Insert Figure 1 here

Individual-level solutions focus on addressing emotional loneliness through strategies that change the behaviours of individuals. A meta-analysis of individual approaches to reduce loneliness was conducted by Masi, Chen, Hawkley, Cacioppo and identified interventions such as improving eye contact and communication styles (such as content, tone of conversation, and personal space); however, these interventions do little to improve the experience of loneliness. Another approach is to apply social-cognitive strategies that include social educational therapies such as reminiscence, counselling and role play. An important element of these interventions is to counter maladaptive thoughts around social interactions, including negative evaluations of oneself or others in social situations, self-defeating thoughts, feeling threatened, and hypervigilance to threat in social situations. Social cognition interventions were reported to be the most effective in reducing loneliness, but only one study was conducted with older people, therefore cognitive interventions require more consideration with this population.

Relationship-oriented solutions can focus on addressing emotional loneliness, such as dating and re-partnering following a divorce. Alternatively, they may focus on addressing risk-factors of loneliness, such as psychosocial treatment after experiencing a bout of depression. Interventions that focus on building bonding relationships can help to create strong, intimate connections between individuals that are uplifting and leave a person with a heightened sense of positive energy. These types of relationships involve mutual awareness and responsiveness, and result in feelings of connectedness and can develop into meaningful relationships over time.

Community-level solutions involve increasing social interaction with others through participation in a diverse range of activities such as befriending programs, intergenerational
programs, animal assisted therapy and e-interventions (e.g., social media and communication training). Many of these interventions are designed to address social isolation (i.e. increase the frequency/amount of time interacting with others), however, community-level interventions also have the potential to address loneliness when they are specifically designed to build high quality social connections. Group activities that focus on building bridging relationships can create a sense of belonging and inclusion and address social loneliness. Activities that are most consistently effective tend to be those that engage people in purposeful group activities (e.g. arts-based, gardening, Men’s Sheds, and physical activity groups), and where a sense of shared connection, identity, and belonging is built among those taking part.

An example of a community-level program in Australia is Groups 4 Health, which provides adults of all ages with the knowledge, skills and confidence to increase their social connectedness, in ways that develop and strengthen their group-based social identifications. Two published trials show that Groups 4 Health reduces loneliness, social anxiety and depression and increases people’s sense of belonging to groups in the community. In providing the strategies to build and sustain group-based belonging, this approach can help older people to make the most of existing groups in local neighbourhoods to support a sense of value and active connection to their community.

Societal level strategies involve entire communities. For example, a program of compassionate communities was launched in Frome, United Kingdom, to reduce isolation and loneliness in older people. The neighbourhood was activated through a suite of social and wellbeing activities, including encouraging general practitioners (GP) to prescribe these initiatives for older residents at risk of social isolation and loneliness. This approach shows what is possible when a neighbourhood is organised and committed to inclusion of all people from different, diverse backgrounds and experiences, including older people, in activities that make the most of everyone’s ideas and strengths, and hopefully combat ageist perceptions. It also shows that active neighbourhoods that engage all community members, including older people, in a range of local activities can improve health and wellbeing. The keys to success are a participatory culture where everyone in the neighbourhood can engage in meaningful ways, enabled by long term strategic support, resources and funding. In addition, codesign, where end users are involved in creating and shaping how community support activities are implemented, is a natural part of the process of developing these supports. The codesigned

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activities better meet their needs, as shown by the continued running of the programs, generally by the community members themselves. The UK has taken this a step further, to support individuals nationally in its social prescribing initiative that employs linkage workers and community navigators in GP surgeries to provide hands on, practical, support to help people make connections. While this approach is developing, early research is highlighting how successful such support can be in reducing loneliness and negative health consequences.\textsuperscript{42}

It is apparent that there is no one size fits all solution.\textsuperscript{22,44} Instead, integrating a suite of existing solutions within a local ecosystem to facilitate increased participation in community-based activities that support holistic wellbeing is likely to be more effective.\textsuperscript{22} This approach builds capacity for social connection that is more likely to lead to the development of increased meaningful relationships across the community and thereby reducing loneliness in a sustainable way.\textsuperscript{22,45} This will include promoting the many purposeful activities that already exist in communities, supported by programs such as Groups 4 Health and social-cognition approaches. A model for social prescribing exists that can be adopted more widely in Australia, however much more work is needed so that older people are viewed as assets to the community.\textsuperscript{44} In addition, studies need to address loneliness as a primary outcome, not just social connection. Research to date suggests that social connection includes the need to have meaningful interactions with others, and the need to feel relevant and a sense of belonging; both need to be considered to reduce the number of people experiencing loneliness in our communities.

Going forward, research is needed to: measure the different types of loneliness; identify what interventions would be most effective, when and how often for individuals to address their subjective feeling of loneliness; identify how best to evaluate the effectiveness of such interventions; ascertain the cost effectiveness of this approach; and how to implement effective interventions nationwide. Investment of funding, resources and commitment to change the structure of how health and social care is delivered and funded will be necessary at every level to enable this approach.\textsuperscript{47} This includes support for services to work together to provide an integrated approach to care.\textsuperscript{48,49} Given the limited effectiveness of siloed care and interventions in preventing and effectively managing non-communicable chronic conditions in general and when considering loneliness, these changes are long overdue.\textsuperscript{50}
Conclusion

Loneliness is a negative emotional response to the absence of close, intimate relationships (emotional loneliness), sense of belonging to social groups, and relevance and inclusion in society more broadly (social loneliness). It is a complex, multi-level issue, which can be brought on by life transitions in older age; and exacerbated by negative, ageist stereotypes that contribute to older people losing their position as meaningful and relevant members of society. This nuanced understanding of loneliness has implications for appropriate innovative and evidence informed interventions to address this important issue.

As loneliness is a complex issue, it requires a suite of codesigned solutions to support the development of a positive sense of self. Activities that give older people a sense of purpose and a life of meaning will likely produce the most effective results. There is wide acknowledgement in the literature that meaningful social networks and the ability to sustain positive personal and social relationships are protective factors against loneliness. An intersectoral approach that includes individual, group and societal-level interventions is needed to support healthy ageing and reduce loneliness. Effective solutions for supporting optimal wellbeing and loneliness are more likely to be found in a social rather than a clinical context.

Australia is currently experiencing a surge of interest on the topic of loneliness, with the establishment of coalitions, alliances and activated neighbourhoods to mitigate loneliness. In addition, the Covid-19 pandemic and Royal Commission into Aged Care Quality and Safety Services have culminated in raised awareness of loneliness at both political and community levels. The result is that Government, at all levels, is now beginning to see the value of programs to reduce loneliness in older people. Further research is required to evaluate the effectiveness of new innovative interventions; and funding is required to translate this evidence into an integrated, community-wide approach to address the underpinning societal issues and optimise wellbeing. This could effectively address loneliness in older people, and also more broadly in all community members.

Practice Impact Statement

Loneliness is becoming one of the most important health issues facing older people. This paper provides a brief overview of loneliness, and emerging innovative community-based programs. It builds on current knowledge by reframing existing theory and
understanding how it is being applied in practice. The paper argues that a multi-level intersectoral approach supported by government funding is required to translate evidence into innovative integrated practice solutions to address the issue.

References


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Figure 1: Levels of loneliness interventions and solutions

Adapted from Mann et al. (2017)⁴⁴, Lim et al. (2020)²⁴, Center for Disease Control, (2020)²⁵


Figure 2: Additional references

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