Social isolation and loneliness among older people: issues and future challenges in community and residential settings

Linda Grenade and Duncan Boldy

Abstract

Although often associated with older age, loneliness and social isolation are not well understood in terms of their prevalence, risk and protective factors. Evidence suggests that only a minority of community-dwelling older people are "severely" lonely or isolated, however a number of factors need to be considered to fully understand the extent and significance of the problem. Community-based studies have identified a variety of risk factors for loneliness/isolation including widowhood, no (surviving) children, living alone, deteriorating health, and life events (eg, loss and bereavement). Having a confidant has been identified as a protective factor for loneliness. However, evidence is often unclear or inconclusive, especially within residential settings. We identified the need to conduct more residential care-focused research; the importance of addressing a variety of methodological concerns; and the need for practitioners to develop intervention programs that are appropriately targeted, evidence-based and evaluated.

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What is known about the topic?

Loneliness and social isolation are known risk factors for various health and related problems among older people. Most literature on the subject focuses on community-dwelling older people. Little is known about the significance of the problem within residential care, or of the relevance of community-based evidence to these settings.

What does this paper add?

This paper provides an overview of loneliness and social isolation among older people, in terms of prevalence, risk factors and current intervention efforts, addressing both community and residential settings.

What are the implications for practitioners?

The limited research suggests that: involving a combination of strategies; involving older people and/or their representative groups in intervention planning and implementation; having well trained, appropriately supported and resourced facilitators and coordinators; utilising existing community resources; and targeting specific groups are likely to result in greater success.

LONELINESS AND SOCIAL ISOLATION are often associated with older age and have been identified as risk factors for a number of health (both physical and mental) and related problems.[1-8] Considerable research attention has been devoted to investigating these issues, particularly in Europe and the United States. Most studies have focused on older people living in the community, although similar problems have been identified in residential care settings.[9-11] To date, only limited research has been carried out in Australia.[12-14]

Regardless of their living circumstances, it is clearly important that older people have access to services and supports which help them to maintain their social connections. This paper provides an overview of issues related to social isolation and loneliness among older Australians, with a focus on the implications for both research and practice.

The concepts

From a research perspective, social isolation and loneliness are generally considered to be separate, although closely related, concepts. Social isola-

Linda Grenade, BA, BSW, PGDipSocResEval, MSc, Research Fellow
Duncan Boldy, CertEd,BSc(Hons), MSc, PhD, Professor
Centre for Research on Ageing, Curtin University of Technology, Perth, WA.

Correspondence: Ms Linda Grenade, Centre for Research on Ageing, Curtin University of Technology, GPO Box U1987, Perth, WA 6845. **l.e.grenade@curtin.edu.au**

tion is usually regarded as an objective state where an individual has minimal contact with others and/or a generally low level of involvement in community life.[15-17] It is often measured in terms of a person's social networks, for example, number and frequency of contacts.[18] Other network-related indicators such as living arrangements (eg, living alone), availability of a confidant, and community involvement are sometimes included.[1,19]

Loneliness, on the other hand, is generally accepted as being a more subjective experience, usually one that is negative or unwelcome.[7,16,20-24] It relates to a person's perception of their social relationships or level of social engagement as being deficient in some way, in terms of quantity and/or quality.[25] The subjective component of loneliness means that a person with a reasonably extensive social network (ie, who would not be regarded as "socially isolated" as described above) may still feel lonely. Conversely, a person may have very limited social networks (ie, regarded as "socially isolated") yet not feel lonely.[7]

In practice, the two concepts are often ill-defined and sometimes used in combination or interchangeably. Moreover, the lack of universally agreed definitions and the variety of measures used have limited the extent to which results of different studies can be meaningfully compared.

What is the extent of the problem?

Community settings

Estimates of the extent of loneliness among older people living in the community vary widely in the literature, with rates as high as 50 to 60 per cent reported in some cases.[5,26] However, most community-based studies indicate that only a minority of older people experience "severe" loneliness — ie, indicate that they feel lonely "always" or "most of the time", or as assessed via specific loneliness scale classification systems. Research by Victor et al[25] in the United Kingdom found that about 7% of the older people included in their study were "severely lonely" and that these levels were similar to those of 50 years previously. Broadly similar

rates have been identified in Northern Europe, North America and the Middle East.[25] A recent (2003) Western Australian study conducted by the authors and colleagues found severe loneliness to be in the order of 7%–9%, depending on the measurement instrument used.[14,27]

Despite these small proportions, evidence suggests that a much larger proportion of older people — perhaps up to one third or more — may experience some degree of loneliness later in their lives.[5,17,25,27] Moreover, it appears that prevalence estimates may vary according to the methods and/or measures used. For example, Victor et al[28] found that in-depth interviews with 45 survey participants revealed a much higher proportion of loneliness (26/45 or 58% of respondents) compared with quantitative survey results. Similarly, higher levels of loneliness have been identified when aggregate measures or scales have been used compared with more "direct", self assessment measures (eg, asking people to rate the frequency of their loneliness on a scale from "always" to "never").[29,30] In an analysis of data from UK and Australian research, Victor, Grenade and Boldy[29] found that although rates of "severe" loneliness were comparable for both types of measure used , the loneliness scale also revealed higher levels of "moderate" loneliness (assumed as broadly equivalent to "sometimes" lonely on the self-rating scale). This suggests that some older people may be more reluctant to admit directly to being lonely, unless it is quite obvious or severe.

Loneliness estimates may also be influenced by the particular population or sub-group under study. Work by Scharf et al[31] in the UK revealed considerably higher estimates of severe loneliness among older people living in low income urban neighbourhoods (15%) than those found in Victor et al's[25] research (7%), which focused on older people living in the general population. Similarly, research suggests that prevalence rates among specific sub-groups, such as older people living alone, and those who are chronically physically or mentally ill, may also be higher than within the general older population.[25]

The dynamic nature of loneliness is an additional consideration when investigating loneliness

prevalence — that is, a person's experience of loneliness may change over time.[25,30] People's experiences of loneliness have also been found to differ according to the time of year and/or day, with holiday periods such as Christmas, and evenings/nights being times when many people may feel more lonely.[14,25]

Unlike loneliness, for which a number of measures have been developed and are widely used, including the UCLA Loneliness Scale[32] and the de Jong-Gierveld Loneliness Scale,[33] there are no universally accepted measures or established criteria for measuring social isolation or its severity. This has posed challenges for researchers. Although estimating prevalence also poses challenges, available evidence indicates that, as for loneliness, the majority of older people are not "severely" socially isolated.[18,27,28,30,34] Victor et al's[34] review of community studies in the UK revealed prevalence rates of about 10% (range 2%–20%). Similar rates have been identified in Australia.[12,13] Evidence also suggests that levels of "severe" isolation are fairly stable over time,[28,30] however a longitudinal study of older people in rural Wales found an increase in levels of "moderate" isolation with advancing age.[30]

Residential care

Little is known about the extent of loneliness and social isolation in residential settings. Given the nature of the residential care environment (ie, communal living, on-site care and support), the likelihood of social isolation is presumably less. However, there is some evidence suggesting that residents may still experience loneliness. In fact, some studies have found levels of loneliness among people living in residential aged care to be higher than for older people living in the community,[5,17,30,35] although Pinquart and Sorenson have suggested that this may be due to factors such as reduced social support and poor health rather than to institutionalisation per se.

Risk and protective factors

From an intervention perspective, it is important to identify factors that may increase the likelihood of a person becoming isolated and/or lonely, as well as those that seem to reduce that risk, and the extent to which some of these might be "amenable" to intervention. Given the interrelatedness of the two concepts, identifying the risk and protective factors specific to each is problematic. However, evidence suggests that many of the same factors are associated with both.[17,30] For the purposes of this section, therefore, the two concepts will be discussed in combination, unless specified otherwise.

Community settings

Again, because most research has been community based, the majority of risk factors identified in the literature relate to community dwelling older people. Some of these factors are socio-demographic and relate in particular to aspects of people's social networks, for example widowhood, never being married, and having no (surviving) children.[18,30,34,36,37] Although living alone has also often been identified as a risk factor for both isolation and loneliness,[17,30] its relationship to loneliness is not entirely clear.[34]

Evidence regarding other socio-demographic factors, such as age and gender, tends to vary. With respect to loneliness, Steed et al[14] suggested that this variability may be related to the type of data (ie, cross sectional versus longitudinal) or measure used (eg, direct question versus a scale where the word "loneliness" is not used), and confounding with other variables. Similarly, evidence for an association between level of education, geographical location (eg, rural versus urban) or material circumstances (eg, limited income) and loneliness/isolation is equivocal.[5,25,34,38-43]

Another group of risk factors relate to health, both physical (eg, poor self-assessed physical health status, chronic illness[21,25,42,44]) and mental health (eg, reported depression, elevated mental morbidity[25]). Although deteriorating physical health (or perceived poor health) is one of the most consistently identified factors, the direction of causation is still not well understood.[25,26] Evidence is similarly unclear in regard to the nature and direction of the association between

isolation and/or loneliness and mental health and/or illness (eg, depression).[17,21,45] A number of studies have found loneliness and/or isolation to be associated with sensory impairments (eg, hearing loss) and physical disabilities.[5,17,25,42,46]

Life events, such as loss and bereavement are further risk factors often identified.[25,43,47] Despite being less researched, available evidence suggests that psychological or personality-related factors such as self-efficacy and self-esteem may also play a role, particularly with respect to loneliness.[17,48-50]

Research on factors that seem to protect older people from becoming lonely or isolated is limited, although it could be assumed, perhaps, that they include the "converse" of the factors described above. Regarding loneliness, it seems that the presence of a confidant is significant.[14,25,49] From a social network perspective, research in Western Australia identified friends as being particularly important, followed by relatives, neighbours and children.[14] The importance of friends has also been highlighted in other studies.[42,51] Victor et al[25] found that education and age, but particularly the latter, also played a protective role; however these findings have generally not been supported in other research.[14,17] Having a pet (eg, dog, cat) has been suggested as protective of loneliness among older people, however empirical evidence is limited and findings equivocal.[52-54]

Residential care

Most of the risk factors discussed above can be assumed to be also relevant to some degree to people living in residential care. Despite the limited research evidence, a number of comments can be made. It seems reasonable to assume, for example, that poor health, frailty and/or diminished cognitive capacity may substantially limit the extent to which aged care residents are able to interact with other residents, both informally and via participation in activities and outings. Not surprisingly, a survey of residential aged care facilities ("care homes") conducted for the Department of Health in the United Kingdom found that participation in organised social activities reduced with increasing frailty and general health deterioration.[55]

Of course, being in a situation of increased dependency implies that residents will have reasonably (in some cases very) frequent contact with staff, thereby potentially reducing the risk of isolation and/or loneliness, and some research has supported this assumption. For example, Dragaset[9] found that dependence on others in carrying out activities of daily living was associated with lower levels of "social loneliness",[23] speculating that the regular contact with staff may have been a key influencing factor. There are a number of issues surrounding resident–staff interactions that need to be considered, however (see later).

From a socio-demographic perspective, a move to residential care clearly brings significant changes to a person's social network structure and functions. Although research suggests that family members often continue to play an important role in a resident's life after admission to long-term care,[56] the frequency and/or nature of contact with them, or with significant others, may change quite markedly. Port et al[57] found that the extent of contact with family and friends decreased by about half compared with reported pre-admission contact.

Similarly, in cases where a spouse or child has played a major caring role, a move to residential care can have a major impact on the nature of their relationship with the resident in terms of, for example, the kind of support the former can now provide, and the level of intimacy between them.[58] In fact, one study conducted in the United States found that the social relationships nursing home residents formed with other residents appeared to be more protective against loneliness than their existing relationships with friends and relatives outside the home.[59]

Although the specific reasons or circumstances may vary, moving to residential care is clearly a major event in a person's life and can be extremely stressful for many individuals. According to Jilek,[11] one of the main reasons for this is the impact of moving from a familiar to unfamiliar environment. Of relevance here is research on elderly hospitalised patients which identified lack of contact with one's familiar environment as a key predictor of loneliness.[60]

Most residents would also experience some form of loss following a move into residential care — for example as a result of having to leave their home, family and friends (and pets in many cases), local communities and previous lifestyles.[10] Moving into an institutional environment, with its rules and routines, where one is dependent on others for care and support, can also have a major impact on a person's ability to retain a sense of autonomy and control over their lives and/or to express their individuality. This may lead to reduced self esteem, loss of identity and depression.[11]

Various other issues that are more specific to the residential care environment may also influence the extent to which residents are able to form meaningful social connections with others within the home itself, as well as with the wider community. One relates to staffing, in terms of factors such as retention, turnover and the increasing reliance on casually employed agency staff.[61] In addition, issues related to interactive/communication skills, and the often diverse cultural/language backgrounds of many care staff, may limit the extent to which meaningful relationships can develop.[11] Also relevant here are the findings of an Australian study which revealed that most staff–resident interactions were predominantly task-oriented in nature.[62] Other research has highlighted the critical role of staff in fostering (or otherwise) a resident's sense of personal autonomy and control, and a sense of self, through the way in which care is provided.[63]

The physical environment of a facility (eg, its size or design) can also influence the way in and extent to which residents interact with each other.[64] Boldy, Chou and Lee[40] found that size had a positive impact on social interaction between hostel (low-care) residents, suggesting that larger facilities tended to provide more social opportunities. However, they also found that residents were less satisfied with their involvement in larger facilities, possibly because smaller ones provided a more personal and "homely" environment. A facility's location within the community, in terms of accessibility and community links, may also be influential.

Little is known about likely protective factors within residential care settings. Some research has indicated that the relationships which residents form within a facility, for example with other residents, can play an important role in compensating for the loss of social networks outside the home, and can provide them with a sense of security and identity.[9,63] Similarly, relationships formed with care staff have been found to parallel those with family members,[65] in some cases replacing the need for an intimate confidant.[9] There is also some evidence suggesting that participation in organised social activities can help to reduce social isolation, as well as increase self esteem and a sense of empowerment.[66]

Interventions to reduce loneliness and isolation

Community settings

A wide variety of interventions aimed at reducing social isolation and loneliness among older people in the community have been implemented at a number of levels, including state and local government and not-for-profit agencies.[67] The nature of these interventions varies from group activity-based (eg, self-help support groups), one-to-one interventions (eg, home visiting), provision of services (eg, transport), to a broader community development focus (eg, social activities aimed at developing community networks and peer support).[68]

Specific goals may include enhancing people's social networks through facilitating their connections with others via, for example, social clubs and group activities, befriending and home visiting schemes, teleconferencing, and computer-based programs, such as email clubs.[67-69] Other intervention goals include promoting personal efficacy (eg, via self-help discussion groups, bereavement support and counselling) and behaviour modification and/or skills development (eg, programs to enhance people's social and/or communication skills).[21,68] Broader level interventions focus on developing community capacity.[69]

In their review of interventions aimed at addressing social isolation, Findlay and Cartwright[67] observed that individual countries tend to channel resources into certain types of programs. In the US, for example, computer or teleconference-based programs were identified as popular; in Canada there was a greater focus on community-based support programs and programs for specific at-risk groups. In Australia, community-based support groups (social clubs and illness-specific groups) are common, although teleconferencing and other telephone-based information and support services were also reported.[62]

Residential care

Information about specific strategies or interventions aimed at addressing social isolation and loneliness within residential care is scarce. However, most residential aged care facilities do have some strategies in place that serve this purpose, albeit indirectly — for example, organised activities that support social interaction between residents, "family friendly" policies and practices, and strategies that help residents to maintain their links with the wider community (eg, outings, organising visits by outside groups). Indeed, many of these are requirements of the Australian residential aged care accreditation system.[70]

Other means include the implementation of policies or strategies that enable residents to have contact with animals — for example, by allowing them to have pets, introducing a "communal" pet, or providing animal assisted therapy.[71] Contact with animals also forms part of the Eden Alternative approach[72] which has been adopted by some long-term care homes as a way of combating boredom, loneliness and lack of meaning among residents. This approach involves the creation of "lush" environments abundant with gardens and plants; also animals and opportunities for interaction with people of all ages, including children (for example via on-site child care facilities and school camps).[73] "External" programs such as the Australian Government-funded Community Visitors Scheme also attempt to reduce the risk of social isolation and promote interaction with the community.[74]

How effective are these interventions?

A critical question is whether these interventions work. Unfortunately, there is little evidence that enables this question to be answered with any surety.[67,68,75] Moreover, evidence regarding the longer term sustainability or benefits of different interventions is scant.[67]

Community settings

Cattan et al's[68] review of 30 community-based intervention evaluation studies, most of which related to either group ($n = 17$) or one-to-one ($n = 10$) interventions, indicated that group interventions, particularly those with an education focus or which involved social activities that targeted specific groups (eg, women, the widowed) were effective. Evidence regarding the effectiveness of one-on-one interventions, such as home visiting and befriending, was unclear.

Another review of interventions by Findlay and Cartwright[67] identified teleconferencing as a potentially useful way of combating social isolation and loneliness for people living in geographically isolated areas, however they added that evidence for the effectiveness of other types of telephone interventions was inconclusive. The authors found some supportive evidence for certain computer-based interventions, such as email clubs. Also suggested as having potential were various community-based initiatives, including "Gatekeeper" programs which have been popular in the US and Canada. These programs use "nontraditional" sources such as mental health professionals or postal delivery people as a means of identifying older people at risk who can then be linked up with appropriate support services.[67,75]

Despite the limited evaluation evidence available, it has been suggested that the most effective interventions share a number of common characteristics. These include: involving a combination of strategies; involving older people and/or their representative groups in intervention planning and implementation; having well trained, appropriately supported and resourced facilitators and coordinators; utilising existing community resources; and targeting specific groups.[67,68,75]

Residential care

Not surprisingly, evidence for the effectiveness of interventions aimed at combating isolation and loneliness within residential care is extremely limited. Nevertheless, it seems likely that most strategies aimed at facilitating the maintenance of contact between residents and their families and friends[9] and/or pets[71,76] will be beneficial. Interventions that provide residents with an increased sense of personal responsibility and choice have also proven effective — for example, structured groups established in response to residents' concerns about social issues.[66]

There is still limited evaluative evidence available regarding the effectiveness of the Eden Alternative, and even less in regard to its psychosocial benefits to residents, although some positive outcomes have been reported in terms of increased social interaction and involvement.[77,78]

Implications and challenges for the future

What does this mean in understanding isolation and loneliness among older people, and what needs to be done? First, there is an obvious need to conduct more research on this topic within Australia, at both national and local levels, particularly in relation to residential care. A number of researchers[17,21] have also identified a need for more longitudinal studies in order that the factors that increase or reduce the risk of isolation and loneliness can be more fully understood. Researching social isolation and loneliness also presents a number of specific challenges. One relates to the confusion surrounding the two concepts. At present, the continued lack of consistency in the way these concepts are operationalised, and the variety of ways in which they are measured, seriously limits the extent to which findings of different studies can be meaningfully compared. Victor et al[34] have also suggested that there is a need for more in-depth research to explore the meaning of loneliness to older people themselves.

A further research-related issue is the likelihood of under-reporting which may be influenced by the methods used. Third, is the ongoing problem of access to and recruitment of potentially "at risk" older people in the community, particularly where language or other issues (eg, cognitive impairment) play a role; recruiting interview participants through third parties can also prove problematic.[79] Access and recruitment may present different kinds of problems in residential care settings — for example, "gatekeeping" by staff (eg, selective approach to identifying "suitable" interviewees), or difficulties finding sufficient numbers of people (including family members) able to participate in a research study.

Service providers and practitioners are faced with other challenges. Findlay and Cartwright's[67] emphasis on appropriate targeting is one such challenge. More specifically, service providers need to identify those older people most at risk and direct their programs and interventions accordingly. As already indicated, available evidence suggests that interventions which target specific groups tend to be more effective.

Related to the above point is Findlay and Cartwright's[67] emphasis on the importance of service providers acknowledging individual differences. As Hicks[10] observed, adopting a "one size fits all" approach to addressing loneliness overlooks the fact that it is an individual experience where causes vary from person to person. Developing programs which incorporate a variety of strategies that can be tailored to suit individual needs may be more appropriate. Findlay and Cartwright also stress the need for service providers to recognise and accept that not all older people wish to participate in such programs, even though they may be isolated and/or lonely. Factors such as physical frailty and/or mental illness (eg, depression) may play a role in regard to the latter.

For practitioners there are also challenges surrounding the choice of interventions. Clearly, there is a need to develop strategies that can help to reduce or eliminate the causes of isolation or loneliness, to the extent this is possible, and to build on those factors that are known to be protective. Given the variety of factors involved, and the complex relationship between them, this

is not an easy task. Finally, service providers must ensure that they involve older people themselves, regardless of where they reside, in the planning and implementation of intervention programs.

In residential care there are additional considerations. One is that the physical frailty and/or cognitive impairment of many residents implies the need to think flexibly and "innovatively" in terms of the way care and services are delivered. As noted by Solomon,[80] organised social groups and activities should be appropriate to residents' levels of cognitive and functional impairment in order that they can obtain maximum benefit. Similarly, Hicks[10] suggests that strategies such as a video exchange program could be implemented for residents whose family and friends live far away in order to help them maintain these links. Timmins[81] has suggested that facilities could also consider strategies that allow for monitoring of loneliness over time — for example, via the use of ecomaps or genograms (ie, tools which help to organise and clarify information about a person's social relationships).

The apparent influence of factors such as self-esteem and sense of control on the experience of loneliness also highlights the importance of residential aged care providers finding ways of enabling residents to retain (or regain) a sense of identity, of meaning and purpose in their lives — to the extent that this is possible. Given the central role that staff play in resident's lives, facilities may also need to assess the way in which care staff interact with residents and whether strategies such as staff training (eg, communication skills) would promote more positive and meaningful relationships. The need to review residential aged care quality assessment practices within Australia, whereby greater emphasis is placed on quality of life indicators rather than quality of care, has also been suggested.[76]

A final group of challenges relates to evaluation. Evaluation should be an integral component of all intervention programs.[75] This implies the need for closer links between service providers and researchers, as well as with governments and policy makers, communities and community groups. Developing stronger connections will not only maximise the chances of appropriate technical expertise and financial support being available, but will also help to prevent unnecessary duplication and foster the sharing of experiences and ideas.

Conclusion

Understanding and addressing social isolation and loneliness among older people, in both community and residential care settings, presents a number of challenges. Based on the issues discussed in this paper, a number of broad suggestions can be made. One is the need for greater cooperation between service providers, researchers, and governments, at all levels, so that the full extent of the problem can be understood and appropriate interventions implemented. Initiatives such as the Queensland Cross Government Project, which involves a variety of organisations and groups, including university researchers, in an effort to address social isolation among older people in that state, is a good example of such a collaborative approach.[82]

The importance of involving older people themselves (or relevant representatives) at all stages of any endeavour aimed at addressing the problem, but in particular in the development of intervention strategies or programs and their evaluation, also needs to be recognised. Finally, there is a need for flexible and innovative thinking on the part of all concerned in order that older people are provided with maximum opportunities to remain a part of their communities and to maintain a good quality of life.

Competing interests

The authors declare that they have no competing interests.

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