Grey areas and gaps: research into loneliness in older age

A wide range of research and evidence on the impact of loneliness creates the foundation on which our campaigning and resources are based. This comes from a range of sources, including academic institutions, surveys, service evaluations and the experience of our supporters.

As loneliness is a very subjective and emotive state, this area of study is not without its ‘grey areas’ and debate – such disagreements can be made more complex by lack of evidence or poor quality studies. We must engage with these if we are to get a handle on what loneliness is, what causes it and how we can improve support for older people at risk of loneliness.

In September 2013, the Campaign to End Loneliness hosted a roundtable at the 42nd Annual Conference of the British Society of Gerontology on the subject of loneliness in older age. With 5 speakers and over 70 attendees, we had a lively discussion about existing research and theory, the gaps in our knowledge and ‘evidence-myths’ in loneliness research.

This short summary captures just some of this debate and discussion from the roundtable, recording as many of the questions or disagreements highlighted by presentations and audience members as possible. Campaigners and practitioners will ultimately benefit by grappling with the many challenges posed by the research base, being honest about what we don’t yet know and pushing for greater support and funding to fill these gaps.

**Presentation: Is loneliness really bad for older people?**

**Professor Christina Victor, Brunel University**

In short: probably. However, we require significantly more qualitative research into the consequences of loneliness to health and wellbeing, particularly as reported by individuals. We have a number of quantitative studies that analyse large data sets but these can contradict each other in conclusions or are misused to support statements about ‘loneliness’ even though they use structural measures (such as living arrangements) and not functional measures (e.g. measuring loneliness, as perceived by the individual).

Such mixing of measures and definitions is a significant problem: loneliness, isolation, living alone and solitude are distinct concepts that can influence our health and wellbeing in different ways. So we need to be certain that we are using research to talk about, or examine, the concept of loneliness, especially when comparing it to more easily defined issues, such as obesity or smoking, to determine its impact.

Using research conducted in other countries can also cause complications. For example, one study in countries of the Former Soviet Union (see slide) found loneliness was a risk factor for excessive drinking in one country (Armenia) but protective factor in another (Moldova). This could be for a number of reasons, such as different cultural understandings of loneliness – but this of course requires more investigation. So we need to critically analyse research into loneliness, boost the amount of qualitative studies and be more precise about what we are examining, if we are to demonstrate how it is bad for older people.
Presentation: Loneliness interventions – are we barking up the wrong tree?
Professor Mima Cattan, Northumbria University

In short: possibly. Four systematic reviews since 2005 have looked at a range of research studies and evaluations of loneliness interventions, and have given us some broad recommendation including:

- Some types of groups are effective, while others are not, or the evidence is less clear
- Older people should be active participants
- Volunteering, one to one support seems to work, but ‘evidence’ not strong or lacking
- Effectiveness of technology based interventions less clear

One challenge is that many studies only measure loneliness at a single point in time; this is a problem because loneliness is not a static state, and can change over the course of days, weeks or even years. A number of studies (and most evaluations) only look at a single type of intervention, which may not capture all of the different factors that influence whether we feel lonely or not.

During the course of years of research into loneliness, many people interviewed by Mima have talked about wanting or need changes in wider determinants – such as housing, environment or transport – to help them overcome their loneliness. If we consider the risk factors for loneliness and indicators of social capital or social inclusion (see image below) we could come to the conclusion that we need a whole new framework for addressing the issue.

An ‘age(ing)-friendly communities’ model may be one such multi-dimension framework. This considers how to improve elements in both the social (social capital; participation in social activities; older people as critical stakeholders) and physical (community design – toilets, seats, pavements; transport; housing) environments (Scharlach & Lehning, 2013). This could therefore better address the range of reasons and situations that can trigger, or worsen, loneliness.

Presentation: Can tackling loneliness reduce health and social service use?
Dr Barbara Hanratty, University of York

In short: “We found no evidence for link between loneliness & isolation and hospital admissions” but “absence of evidence is not absence of effect”. As a practicing GP, Barbara was aware that a number of older people coming into the surgery seemed to be lonely – but felt that there should be a better way of meeting this type of need. However, the evidence base on whether feelings of loneliness influence use of health and care services is far from conclusive. There is also the challenge that conflicting conclusions are drawn by the UK and USA research.

The impact of loneliness on a range of services was considered but, because of time limitations, this presentation focused on the relationship between loneliness and hospital admissions. 21 studies were found that looked at hospital admissions and loneliness, of which only 3 papers explicitly measured loneliness. A further 5 used a mix of structural and functional measures, and the rest just structural (e.g.
marital status, living arrangements). 5 out of 21 said loneliness did increase hospital admissions, but disagreed on the direction of relationship between the two. The rest found no link.

However, throughout the whole review the quality of studies was an issue. It was clear that a better understanding, and use, of a robust definition of loneliness was needed. So even though there was not enough evidence to conclusively say that loneliness increased use of health or care services, better quality studies, with comparable data, could still find a link. A mixture of quantitative and qualitative methods could help provide this.

Presentation: Is loneliness a risk factor for admission to care homes?
Danielle Moore, University of York

In short: we can cautiously say, yes. There is some evidence for an association between social support, isolation or loneliness and moving into care homes. However, a previous systematic review looking for risk factors for entry into residential care (by Luppa et al) in 2010 did not find strong evidence for it as a predictor of institutionalisation.

Danielle used the English Longitudinal Study of Ageing (ELSA) to investigate further the link between loneliness and care home admission. ELSA has two measures of loneliness: the UCLA 3-item scale and the Centre for Epidemiologic Studies Depression Scale (which includes the item “In the past week, have you felt lonely?”).

Because ELSA does not have questions on loneliness in every wave, and few respondents are admitted to care homes over the course of the data collection, the study concludes cautiously that there is a positive association. However, there is a significant amount of further research that would be needed (see slide) including answering the questions does loneliness persist after admission?

Presentation: Loneliness, Isolation and the Bridging Social Capital of Elderly Europeans in Cross-National Comparison
Stefanie Doebler, Swansea University

Using an on-going research project, this presentation asked the question ‘why do older Southern Europeans report higher overall levels of loneliness (Fokkema et al., 2012), despite the stereotype that family ties are stronger in Europe’s south?’ The research intended to test the Putnam (2000) theory that the lack of social capital, or the wrong kind of social capital, is why people experience loneliness.
Autonomy (in choosing relationships, e.g. you can pick your friends but not your family) might also play a role in whether adults experience loneliness or not. Contact with friends and family is obviously a protective factor against loneliness, but contact with family could be less important than with friends.

The European data set used (Survey of Health and Retirement in Europe: wave 2 and wave 4) has two different loneliness measures in two waves, which has led to conflicting results in levels of loneliness (see slide below). This demonstrates that we have to be careful about the question we use in studies, and raises the question if understanding of what loneliness is why levels vary by country across Europe.

An in-depth analysis of Italy showed that contact with friends seemed to be more important than family (but this was not the case for other countries). A tentative conclusion is that, in Southern Europe, friends may be a more protective factor but this could be related to cultural expectations.

Other questions and discussion

- Several attendees made points, or asked questions, about how researchers should be engaging with the theory of loneliness. It was suggested that the social relationships paradigm of loneliness may not be adequate – attendees suggested a new theory of loneliness could considered in relation to factors such as disability, loss and bereavement

- Bereavement was discussed in slightly more depth – it was observed that we have years of research and experience into supporting people who had been recently bereaved, and that this should be applied to the design and development of loneliness interventions

- It was agreed by a number of speakers that there is a growing need to ensure all studies measure loneliness and not other proxies, if it is loneliness that they seek to investigate

- It was observed that roughly 10% of the older population in the UK are chronically lonely, but we don’t know what the protective factors are for the other 90%. We could benefit from exploring what helps build resilience to chronic loneliness, and what positive lessons could be learnt – which in turn could help improve interventions

- It was mentioned by both speakers and audience members, that we need to commission more mixed research that includes both quantitative and qualitative methods – purely quantitative studies appear to come with contradicting conclusions, and we still lack understanding on the consequences of loneliness as reported by individuals

- One audience member proposed that over 60 years of research by universities has not got us particularly far and it may be time to start somewhere different, such as with the services and support already on offer for older people. Others agreed that we could benefit from more action research into loneliness in older age

- A number of gaps in our knowledge were raised during the roundtable, including the fact that we do not yet know how the ‘mode’ (i.e. offline/online) of relationships can influence loneliness