

# Loneliness and ageing: Ireland, North and South

## Summary Report



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Prepared by:

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# Loneliness and ageing: Ireland, North and South

*This is a summary of a research paper by Brian Harvey and Kathy Walsh. The paper was commissioned by the Centre for Ageing Research and Development in Ireland (CARDI) which is now the Ageing Research and Development Division of the Institute of Public Health in Ireland (IPH). The purpose of the research was to examine the concept of loneliness and to identify the most effective policy and service interventions to address loneliness amongst older people in Ireland, North and South.*

## Introduction

Chronic loneliness affects about 10% of older people<sup>1</sup>. Factors that influence loneliness include health, depressive symptoms a range of individual and environmental influences. Factors that protect against loneliness include social participation and social resources. Loneliness can have a broad range of negative impacts on physical and mental health therefore it is an issue increasingly of concern to those engaged in public health work.

## Defining loneliness

*Loneliness can be defined as the subjective, unwelcome feeling of lack or loss of companionship or meaningful relationships, emotional and social by nature, relating to opportunities to socialise, social networks and support from friends or allies in time of distress (Cattan et al, 2003).*

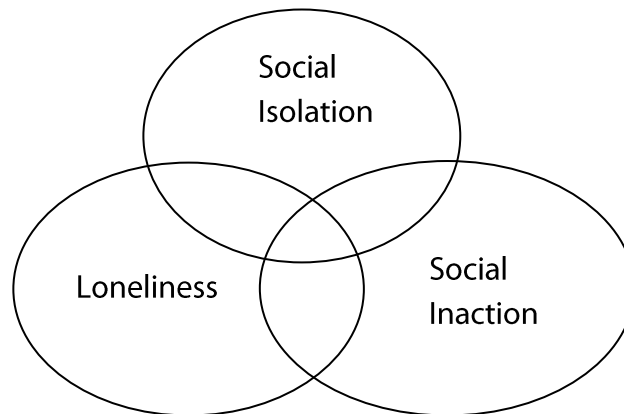
Loneliness can be transient, a feeling that occurs from time to time, at a particular stage in life or associated with specific life events or chronic where a person feels lonely most or all of the time. Loneliness may be associated with social isolation and social inaction but it is not the same thing (see Figure 1 for relationship between these concepts).

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<sup>1</sup> Victor C (2011) 'Loneliness in old age: the UK perspective. Safeguarding the convoy: a call to action from the Campaign to End Loneliness' Age UK Oxfordshire.

**Figure 1: The relationship between social isolation, social inaction and loneliness**

Social isolation is characterised by an absence of social interactions, social support structures and engagement with wider community activities or structures.



Social inaction describes a state where individuals chose or are unable to take part in social action and are disconnected from concepts of 'wellness' and civic society.

Loneliness describes an individual's personal subjective sense of lacking connection and contact with social interactions to the extent that they are wanted or needed.

(Source: Henderson, 2013)

*90% of older adults visit with family or friends once per week or more. Women visit more than men and frequency of visit increases with age (TILDA, 2011).*

Loneliness can occur at any age but research suggests that older people may be impacted to greater extent at both physical and mental levels by experiencing loneliness. Loneliness levels may follow a U-trajectory over an individual's lifetime, being generally higher in teenage years, low during family formation and working age, rising again in older age (Victor, 2005).

### Three theories of loneliness

- A **social needs approach** which focuses on the need for contact and how this need continues throughout adult life;
- A **cognitive approach** which is predicated on the recognition that loneliness will be experienced when a person perceives that his or her social involvement is less than what they would want it to be in terms of quantity and quality and
- An **existential approach** which focuses on the human condition and on an awareness of one's own mortality.

## Loneliness risk factors

Individual	Societal factors
<ul style="list-style-type: none"><li>• Age</li><li>• Gender</li><li>• Ethnicity</li><li>• Health</li><li>• Socio-economic status</li><li>• Sexual orientation</li><li>• Personality and personal circumstances</li></ul>	<ul style="list-style-type: none"><li>• Presence or absence of pre-existing social networks</li><li>• Cultural factors</li><li>• Environmental factors</li></ul>

## Groups at risk of loneliness

### ***Members of the Lesbian, Gay, Bisexual and Transgendered (LGBT) community***

A 2011 study by the Gay & Lesbian Equality Network on the needs and experiences of older Lesbian, Gay, Bisexual and Transgender (LGBT) people in Ireland identified 'loneliness and isolation as issues for 30.9% of its ageing community (Higgins et al, 2011).

### ***Individuals living with dementia or cognitive impairment***

Individuals living with dementia are more at risk of loneliness than the general population (Alzheimer's Society, 2013). This risk increases if the person with dementia lives alone.

### ***Individuals with a physical disability/ mobility issues***

Individuals living with a physical disability and or mobility issues can find themselves physically isolated, marginalised and lonely (Russell, 2009).

### ***Individuals with an intellectual disability***

Research has found 'some level of loneliness was a common experience' among adults with an intellectual disability in the Republic of Ireland (McCarron et al, 2011, p.47).

### ***Individuals who are caring for a family member or friend***

The loneliness experienced by carers is caused by a range of circumstances including a lack of time or energy to sustain contacts/relationships with friends or wider family (Ekwall et al, 2005).

### ***Individuals from ethnic minority/minority communities***

Within ethnic minority populations, households are often perceived to have more 'traditional' family structures and therefore at lower risk of loneliness. There is a danger that the support needs of older members of these communities in relation to loneliness may be underestimated. Language can be a barrier for individuals from minority communities, with research showing that individuals from this community experiencing

dementia often lose whatever second-language ability they had (Campaign to End Loneliness, 2014).

## The Impact of Loneliness

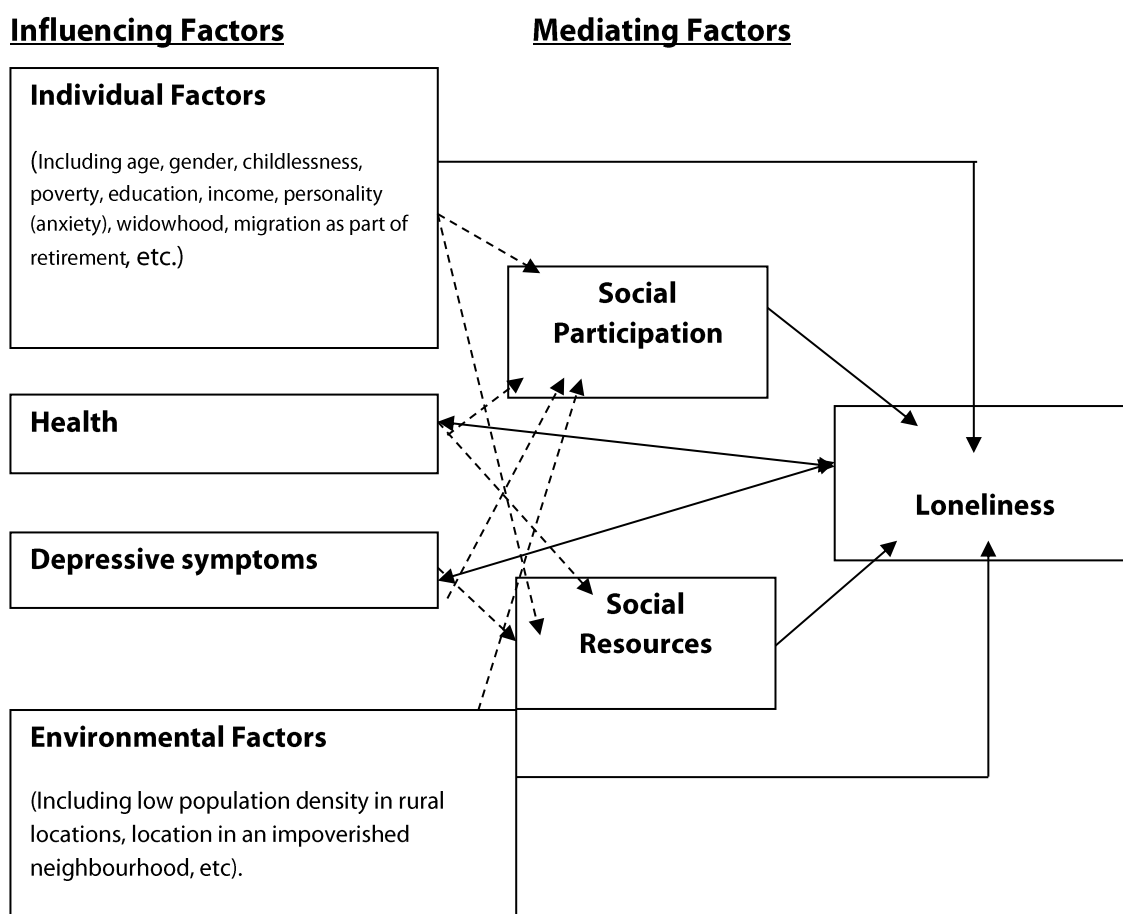
Although the experience of loneliness clearly affects health and quality of life, it is not clear whether loneliness causes these, or indeed whether poor health and a declining quality of life are triggers for loneliness. However, loneliness has been linked to a wide variety of mental and physical health outcomes, such as depression, nursing home admission, and overall quality of life for older people (Timonen et al, 2011).

Loneliness has also been linked to **cognitive decline and dementia** in older people with evidence that socially engaged older people experience less cognitive decline and are less prone to dementia (Conroy et al, 2010; James et al, 2011).

## Factors that can protect/mediate against loneliness

Figure 2 shows an overview of some of the factors that influence loneliness and the factors that can protect/mediate against loneliness.

**Figure 2 Factors that influence and factors that mediate against loneliness**



Source: Burholt and Scharf (2014)

## Interventions to tackle loneliness

It is clear that loneliness requires a variety of interventions at a range of levels – individual, familial, social, community, state, voluntary – and these will all work differently depending on the circumstances of the individual concerned (Figure 3 shows how interventions must operate at a number of levels).

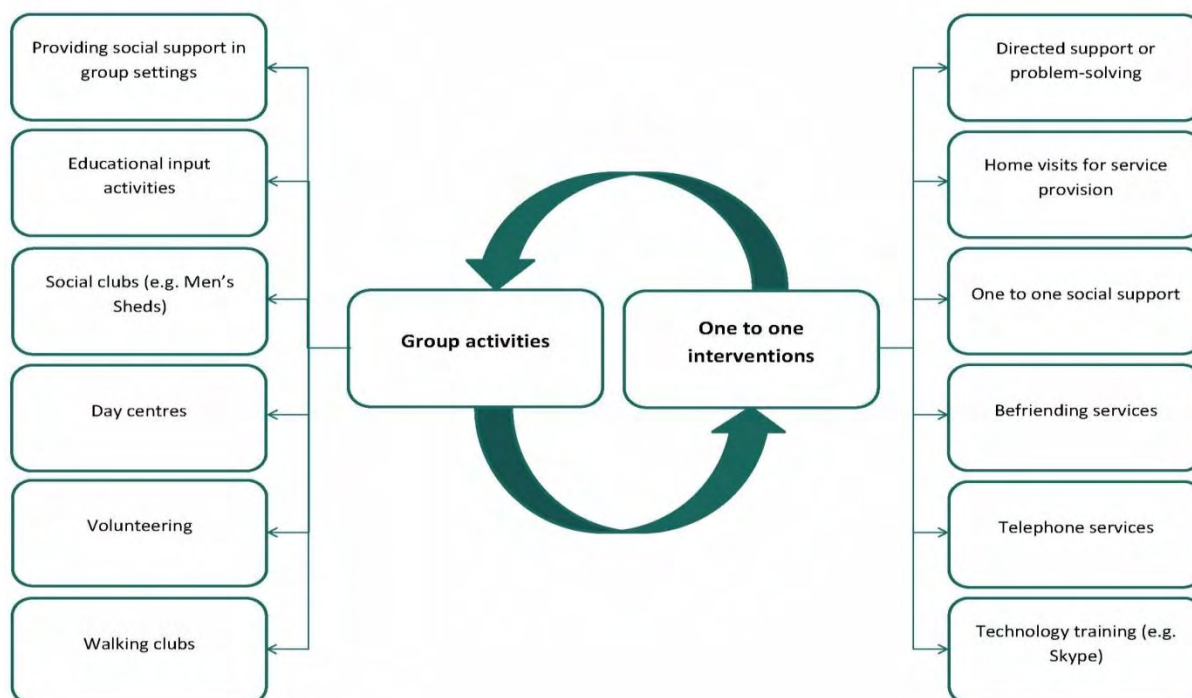
### Methods and examples

**Befriending services:** mainly run by voluntary and charity groups these services use volunteers to actively go and befriend older people through home visits and telephone e.g. ALONE in the Republic of Ireland. Befriending services have the advantage of low cost, practicality, media appeal and offer a clearly defined role for volunteers. However, their value as a means of combating loneliness has with some exceptions been difficult to prove (Cattan and White, 1998).

**Group activities:** where older people are encouraged to engage in social activities outside their home environment e.g. Active Retirement Ireland and Engage with Age in Northern Ireland. Community-based activities have been found to have positive outcomes in addressing loneliness but are often more costly and complicated to establish.

**Tailored programmes that promote friendship building:** tailored programmes that focus on supporting and encouraging older people to build their own social networks and friendships e.g. Netherlands and online interventions e.g. V2me.

**Figure 3 Interventions to tackle loneliness**



(Source: Cattan et al, 2003)

## Recommendations

### **1. Develop and foster a better understanding of the concept of loneliness**

While social isolation, social inclusion and loneliness are related and often used interchangeably they are distinct concepts. Loneliness involves both a psychological state and a subjective experience (*i.e.* a negative emotion associated with a gap between the quality and quantity of relationships an individual has and wants). Tackling loneliness and particularly chronic loneliness requires a complex response based on an understanding of the various (affective, cognitive and subjective) components of loneliness.

### **2. Identify chronic loneliness as a social health priority**

While loneliness is both a social and a wider (social) health issue, the absence of an adequately resourced social inclusion policy framework means that for pragmatic reasons loneliness needs to be identified as a prominent and clearly defined priority and field of work within the wider health policy arena.

### **3. Ensure that loneliness interventions are based on evidence**

Those designing services to combat loneliness need to carefully consider the evidence base of what is known to work. There is evidence to suggest that services designed to tackle chronic loneliness work best where they use a multiplicity of methods and approaches (communal socialisation is generally just one of a number of approaches used). These services also need to be designed in such a way that they can accommodate individuals who may otherwise be unable, for health, social or geographic reasons, to take advantage of them.

### **4. Establish services and initiatives to tackle chronic loneliness**

Chronic loneliness is linked to a wide range of mental and physical health and quality of life outcomes. Therefore it may be argued that there is a need for services/initiatives both to tackle chronic loneliness and to identify and support individuals at risk of chronic loneliness. These services and initiatives need to involve both statutory bodies and voluntary and community organisations and appropriate resources.

### **5. Support the development of a strong evaluation culture**

Evaluation needs to be included as a core element of all of projects, services initiatives funded to tackle loneliness. Supporting the development of an evaluation culture and evaluation expertise among and between statutory and voluntary organisations would be an important initiative in this context. Over time this could be extended to ensure information, news and examples of good practice are circulated widely on both parts of the island.



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Institute of Public Health in Ireland

5th Floor  
Bishop's Square  
Redmond's Hill  
Dublin DO2 TD99

Forestview  
Purdy's Lane  
Belfast  
BT8 7AR

Ph: 00 353 1 4786300  
Fax: 00 353 1 478 6319

00 44 28 9064 8494  
00 44 28 9069 4409

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