Loneliness

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Synonyms

Emotional loneliness; Perceived social isolation; Social loneliness

Definitions

Although the definitions and measurements of loneliness in the literature are not consistent, loneliness is usually defined as a subjective, negative, and distressing feeling due to deficits in social contacts, either quantitatively or more important qualitatively (De Jong-Gierveld 1987; Nicolaisen and Thorsen 2014; Perlman and Peplau 1981). Loneliness can be distinguished into three components: (1) emotional loneliness, which is due to the absence of an intimate relationship or a close emotional attachment, (2) social loneliness that arises when a broader group of social contacts is absent (Weiss 1973), and (3) collective loneliness that refers to the perceived absence of a

meaningful connection with a group (Cacioppo et al. 2014). Loneliness is not equivalent to social isolation; the latter refers to the objective deficits of social contacts or interactions (De Jong Gierveld et al. 2006).

Overview

Regarding the measurements of loneliness, there are at least three widely used measures in the literature. The first is the UCLA loneliness scale, including the 20-item (Russell et al. 1980) and a shorter version of 3-item scales (Hughes et al. 2004). The second one is the 6-item De Jong Gierveld scale (De Jong Gierveld and Tilburg 2006), and this scale can be used to measure emotional and social loneliness. In addition, a single-item question of “Do you feel lonely” is also widely used in a large survey due to its simplicity (Dahlberg et al. 2015; Luo and Waite 2014; Victor et al. 2005).

In terms of the prevalence of loneliness, findings are inconsistent due to the various measurements used in the literature. For instance, Gerst-Emerson and Jayawardhana (2015) found that the prevalence of loneliness in older Americans was 52.7% in 2008 and 56.6% in 2012 using a 3-item R-UCLA loneliness scales (Hughes et al. 2004) based on Health and Retirement Study. Based on Office for National Statistics (ONS) Omnibus Survey of households in Great Britain, Victor et al. (2005) found that among older respondents,

31% reported “sometimes” lonely, 5% “often” lonely, and 2% “always” lonely using a single-item measure. Victor and Yang (2012) found that 7.4% of the older adults reported lonely all or most of the time, 18.4% lonely some of the time, and 74.2% never lonely based on the third round of European Social Survey conducted in 2006 using a single-item measure. Yang and Victor (2008) found that the prevalence of loneliness was 15.6% in 1992 and 29.6% in 2006 among older adults in China using a single-item measure.

Given the variety and inconsistency of measurements of loneliness, it is thus difficult to compare the prevalence across cultures and over time, and the trends may differ from countries to countries. For example, regardless of the different measurements, research shows that the loneliness level in Chinese older adults increased by 1.2 standard deviations from 1995 to 2011 (Yan et al. 2014) and the prevalence increased from 15.6% in 1992 to 29.6% in 2006 (Yang and Victor 2008). However, Dykstra (2009) found that loneliness has decreased slightly in Europe. Nevertheless, the prevalence of loneliness in older adults might be underestimated, as acknowledging loneliness indicates a lack of satisfactory family support or weak coping abilities (Yang et al. 2018).

Key Research Findings

Correlates of Loneliness

Both cross-sectional and longitudinal empirical studies suggest that correlates (or associates/predictors) of loneliness can be classified into three domains: sociodemographics, health conditions, and psychosocial factors (e.g., Pinquart and Sorensen 2001; Dahlberg et al. 2015). Sociodemographic associates include being older (Pinquart and Sorensen 2001), living alone (Finlay and Kobayashi 2018), being unmarried (Dahlberg and McKee 2014), and having a lower socioeconomic status (SES) (Hawkey et al. 2008). These sociodemographic factors mainly reflect lower material and emotional supportive resources that can be used to cope with loneliness. Regarding health factors, older adults with poorer health (e.g., disability, cognitive impairment) tend

to experience a higher level of loneliness, as poorer health can hinder the maintenance of social contacts and can limit daily activities that they could utilize to cope with loneliness (Pinquart and Sorensen 2001). Psychosocial factors, such as low social contacts and poor social relationships, have been associated with loneliness because supports from the social contact and relationships could buffer psychological distresses and loneliness (Pinquart and Sorensen 2001; Zhong et al. 2018).

Recently, some studies have considered the possible impact of the pandemic of the coronavirus 2019 (COVID-19) on older adults' loneliness (Brooks et al. 2020; Wang et al. 2020). However, no empirical studies have been conducted to date due to the lack of data. While mandatory restrictions of physical distancing and shelter-in-home are important for mitigating the transmission of the virus, it also may incur or exacerbate feelings of loneliness in older adults, especially those who live alone. Furthermore, older adults with confirmed cases of the COVID-19 may be particularly fearful of the severe consequences of the disease; and those without infection may be fearful of contracting the disease – leading to new or increased anxiety and/or depression. Previous research has shown that mandatory quarantines and contact tracing by health authorities during the SARS outbreak had a negative impact on individuals' mental health (Brook et al., 2020). In the context of such pandemics, older adults may face greater risks of loneliness.

Findings from Life-Course Approach

Life-course perspective has shed light on the understanding and interventions of loneliness. There are three conceptual models, named the critical (sensitive) effect model, the cumulative effect model, and the social trajectory effect model (Berkman 2009; Gu et al. 2017; Hallqvist et al. 2004). The critical effect model claims that exposures at a specific time period would produce a stronger effect compared to those happening in other time periods. The cumulative effect model proposes that exposures accumulate and increase the risk of a certain outcome. The social trajectory model states that early-life conditions may impact

adulthood social conditions, which in turn influence later-life conditions. Empirical research based on a life-course perspective revealed interesting findings. For instance, childhood measures, such as negative memories of relationships with parents in childhood, experiences of being bullied, conflicts between parents, and economic problems in their childhood family, significantly predicted loneliness at old age (Merz and De Jong Gierveld 2016; Nicolaisen and Thorsen 2014). In addition, moving from rural to urban areas has been found to be correlated with lower odds of loneliness incidence in China (Yang and Gu 2019).

Consequences of Loneliness

Loneliness in older adults is an increasing public health issue, because it imposes a variety of health risks on older adults. Indeed, consequences of loneliness are always an indispensable part of loneliness research. Loneliness is evidenced to increase risk of various health outcomes, including mortality (Luo et al. 2012; Luo and Waite 2014; Patterson and Veenstra 2010), dementia (O'Lunaigh et al. 2012; Zhou et al. 2018), worse mental health (e.g., well-being, depression, suicide) (Leigh-Hunt et al. 2017), and functional decline (Perissinotto et al. 2012). For instance, Zhou et al. (2018) found that loneliness increased the risk of dementia onset in Chinese older adults when accounting for other covariates. Perissinotto et al. (2012) found that loneliness was associated with a decline in ADL, mobility, climbing, and an increase in mortality. Loneliness also increases higher health-care utilization (Gerst-Emerson and Jayawardhana 2015). Despite the fact that most research suggests that loneliness exerts a detrimental effect on older adults, Cacioppo et al. (2014) argued that loneliness could serve as an adaptive biological capacity from an evolutionary perspective, as loneliness can prompt lonely individuals to build connections with others in order to alleviate the lonely feelings.

Possible Mechanisms for the Loneliness-Health Linkage

Loneliness could impact health through several mechanisms, including health behaviors,

neurobiological functioning, and psychological-cognitive processes (Cacioppo et al. 2003; Hawkey and Cacioppo 2010; Ong et al. 2016). First, loneliness is associated with unhealthy behavioral practice, such as smoking, poor sleep quality, and sedentary lifestyle. Second, the neurobiological mechanisms indicate that loneliness is related to diminished immunity, elevated blood pressure, and dysregulation of the hypothalamic-pituitary-adrenocortical (HPA) axis, which in turn lead to a variety of diseases. Lastly, the psychological-cognitive processes suggest that loneliness is associated with impaired executive functioning, increased sensitivity to aversive social stimuli, and unsatisfactory social relationship.

Intervention Outcomes

Given the increasing level of loneliness and negative consequences of loneliness in the context of increasing population aging, efforts have been made to eliminate loneliness and to enhance their well-being in older adults. Different intervention strategies have been developed and identified in the literature, including improving social skills, enhancing social support, increasing opportunities for social contact, and addressing maladaptive social cognition (Masi et al. 2010). Intervention types included one-to-one, group intervention, service provision, and Internet usage (Findlay 2003). Factors that are important to eliminate the loneliness level in older adults in interventions include targeting specific groups, using more than one method, allowing participants some level of control (Cattan et al. 2005), adaptability, a community development approach, and productive engagement (Gardiner et al. 2016), and targeting maladaptive social cognition (Masi et al. 2010). Due to the advancement in technology and Internet, research shows that computer and Internet programs are effective in managing loneliness in older adults (Choi et al. 2012). During the COVID-19 pandemic, programs that expand access to telehealth for older adults who need medical care for mental health and increase access to utilities such as the internet and smartphones for all older adults may yield significant positive outcomes by ensuring that

vulnerable older-adults stay connected. Overall, future interventions with more sound theoretical background and improved study designs are needed to more effectively reduce loneliness in older adults.

Future Directions of Research

Despite research to investigate loneliness in older adults, there are still some limitations in the literature, and future research is needed to address research gaps as follows. First, loneliness is a subjective and unpleasant feeling that is shaped by cultural context, and the meaning implied by loneliness in different cultures might be different. Thus, cross-cultural comparisons are needed to examine the meaning of loneliness from the perspective of older adults, to refine the measures that suit best for the population in a specific culture, and to compare the prevalence and correlates of loneliness. Second, the aging population is not homogeneous, varying in terms of health level, socioeconomic status, marital status, living arrangement, and other conditions. A better understanding of associates of loneliness in subgroup populations, especially those disadvantaged groups (e.g., the oldest-old, minority older adults, older adults in poverty, disabled older adults, refugees) with different characteristics, is needed. Third, life-course perspective and the role of contextual factors in loneliness are relatively neglected in the literature, and future research is needed to adopt these approaches to more fully investigate loneliness. Fourth, given the facts that we are entering an Internet-dominated society and that Internet use is getting popular among older adults (Seifert and Rössel 2019), how to develop various intervention programs to ensure older adults to benefit from advancement of technology and help them manage their loneliness would be a key for achieving healthy aging. Fifth, there is emerging evidence that the needs of older people in crises or emergency situations (e.g., conflicts, violence, displacement, disasters, epidemics or pandemics) have not been properly addressed (Hutton 2008). To date, the literature on loneliness among these older adults is almost nonexistent,

indicating an urgent need for more research. In the case of a public health pandemic, such as the COVID-19 outbreak, research should examine not only the impact of the infection status on loneliness but also examine how the severity of infection may further impact loneliness could improve our understanding on how this (and other) pandemics influence loneliness in older adults. Lastly, interdisciplinary and multilevel efforts based on a biopsychosocial framework and longitudinal data that include policy-, community-, family-, and individual-level factors are needed in future research and intervention to more effectively address older adults' loneliness.

Cross-References

- Digital Participation
- Disengagement Theory
- Distress
- Geriatric Depression Scale
- Life Course Perspective
- Marginalization
- Social Integration
- Social Isolation
- Social Participation
- Subjective Well-being

Disclaimer: Views expressed in this entry are solely of those authors and do not necessarily reflect the views of the United Nations or Shanghai University.

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