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Loneliness and Old Age : critical clinical issues

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ABSTRACT

Loneliness is a major problem in old age. Levels of loneliness are relatively stable across most of old age, but correlates of loneliness show differences. We review the data available on loneliness in old age and its effects on health behaviors, stress exposure, physiological stress responses, appraisal, coping, and restorative processes. The effects of each of these pathways endow loneliness with the capacity to accelerate the rate of physiological decline with age. Additional research across the lifespan is required to understand the nature of accrued loneliness effects on health behavior and physiology in the short and long term. The review suggests that educational and social activity group interventions that target specific groups can alleviate social isolation and loneliness among older people. Managing loneliness in the elderly will reduce psychological and physical morbidity to large extent in this population.

KEYWORDS : Loneliness, old age

Introduction

Loneliness, is the unpleasant experience that occurs when a person's network of relationships is felt to be deficient in some important way (De Jong Gierveld, 1987; Peplau and Perlman, 1982). One hallmark of loneliness is that it is a subjective experience and a second is that it involves negative affect (Weiss, 1987). Loneliness is more strongly associated with qualitative than with quantitative characteristics of relationships (Hughes et al., 2004; De Jong Gierveld, 1998). It is important to draw the distinction between loneliness and social isolation (De Jong Gierveld et al., 2006). Loneliness is a negative, subjective experience, whereas social isolation is the objective condition of not having ties with others. There are two components of loneliness i.e. emotional and social loneliness (Drennan et al., 2008; Dykstra and Fokkema, 2007). Emotional loneliness is missing an intimate attachment, such as a marital partner, and is accompanied by feelings of desolation and insecurity, and of not having someone to turn to (Perlman, 2004). Social loneliness is lacking a wider circle of friends and acquaintances that can provide a sense of belonging, of companionship and of being a member of a community (Van Baarsen et al., 2001).

Explanations of loneliness are generally sought in three sets of factors (De Jong Gierveld et al., 2006; Pinquart and Sorensen, 2001). The first pertains to social network characteristics viz. the number and the quality of the relationships in which people are involved. People who are unmarried are lonelier than the married, and that those with small, unsupportive networks are lonelier than those who are actively involved in social networks (Stokes & Levin, 1986). The second set of determinants pertains to relationship standards viz. the preferences, expectations and desires for personal relationships. A focus on relationship standards can help understand why people who are socially isolated do not feel lonely, or why people who are embedded in large networks nevertheless feel lonely (Dykstra and Fokkema, 2007). The third set pertains to predisposing conditions. Poor self-esteem is one of them: people who lack confidence might be inhibited in their social interactions, and might not be attractive to others (Victor et al., 2000). This review article provides a survey of the literature on older adult loneliness and critical clinical issues that pertain to them.

Loneliness in Old Age – certain facts and myths

The image of the elderly is that of an overwhelmingly lonely group (Tornstam, 2007; Victor et al., 2002). In surveys carried out among the general public, loneliness is often named as a very serious problem for older adults (Tornstam, 2007; Victor et al., 2002). In a recent US study (Abramson and Silverstein, 2006) respondents greatly overestimated the prevalence of loneliness in the older adult population. 61% of 18–34-year olds, 47% of 35–64-year olds, and 33% of those aged 65 and above perceived loneliness as a serious problem for people over 65. In other words, people tend to attribute higher levels of loneliness to the elderly than the elderly themselves experience (Victor et al., 2000).

Jylha and Jokela (1990) formulated the hypothesis that older adults who live alone are more likely to feel lonely in countries where living alone is uncommon. In other words, loneliness should be more prevalent in societies where living alone is more of an exception than a rule. The authors based this hypothesis on Johnson and Mullins' (1987) concept of the 'loneliness threshold'. This concept holds that people have their own minimal standards for social contacts, determined by two closely related factors i.e. the cultural value system in a society and the amount of social contacts to which people are normally accustomed. In more collectivist cultures, pressures and expectations of communality are likely to be higher than in a more individualist type of culture. Living alone is more typical of individualistic than of collectivist societies. Among the studies focusing on cross-national differences in loneliness, explanations in terms of interaction effects are most often practiced, probably because the number of countries with comparative loneliness data tends to be small (Anderrson, 1998).

Loneliness as a problem specifically for older people finds only partial support in research findings. Loneliness is common only among the very old, that is, those aged 80 and over (Palsson & Skoog, 1997). Loneliness levels show little variation across midlife and early old age, whereas young adulthood is characterized by a relatively high prevalence of loneliness (Rotenberg & Hymel, 1999). There are two explanations for why older adults are not as lonely a group as stereotypes suggest (Perlman, 1988). The first is that the desired levels of contact might drop as rapidly as the actual level of contact. The second is that older adults might have higher ratings of the quality of their relationships. Older adults might be less lonely because they feel their social circumstances compare favourably in terms of earlier expectations or relative to peers (Perlman, 1988).

The authors wish to remind the general public that older people can still adapt well, enjoy life, and prosper in spite of the effects of aging. Researchers argue that age segregation fosters ageist attitudes (Hagestad & Uhlenberg, 2006). Our societies are characterized by spatial, cultural and institutional arrangements that segregate old and young persons from each other, and restrict opportunities for individuals to form stable cross-age relationships (Jylha, 2004). Although ageist stereotypes can be reduced through education that intentionally aims at suppressing them, building sustained familiarity with individuals in other age groups is the safest route for breaking down prejudice and preventing discriminatory behaviours (Jylha, 2004). Residential, recreational and work settings which facilitate 'mutual socialization' between the young and the old are essential to promoting knowledge of other age groups and reducing stereotypical judgments (Jylha, 2004).

Another commonly held assumption is that loneliness in the elderly has increased over time. Findings showed the opposite trend i.e. levels of loneliness have been decreasing over time, albeit slightly, or they have remained unchanged, depending on the studies that are considered. Loneliness is not the only outcome showing a change for the better but in fact average happiness has increased slightly in rich nations and considerably in developing nations (Veenhoven and Hagerty, 2006).

Greater reflexivity, which means an increased tendency for individuals to reflect actively and critically on their experiences and relationships, might be the driving force behind the decline in loneliness and the improvement in personal relationships. One of the transformations of late modernity is that people are architects of their lives (Giddens, 1991). Authors argue that individuals are more open to the possibility that relationships can be changed through individual agency rather than tacitly accepting them as a given of social life (Allan, 2008). Presumably, people both young and old, are nowadays better motivated and better skilled at maintaining satisfying relationships.

Loneliness and health in old age – critical factors

Research over the past several decades has repeatedly shown that a lack of social ties in the elderly increases the risk for poor health (Seeman, 2001). Older adults are disproportionately represented in the growing segment of socially isolated adults, and despite increased prevalence of loneliness in older adults, loneliness levels are relatively stable across the lifespan, at least until the oldest old age i.e. 85 years and older. (Demakakos et al., 2006). Age-related similarities in loneliness levels do not necessarily mean age-related similarities in the correlates or consequences of loneliness (Rokach et al., 2004). Loneliness contributes to, and accelerates, age related decreases in physiological resilience through its influences on health behaviour, stress exposure, psychological and physiological stress responses, and restorative processes that replenish physiological reserves and fortify against future stress (Rokach et al., 2004). The working hypothesis is that loneliness hastens physiological decline through its association with one or more pre-disease pathways, and that the contributory pathways may differ in kind and potency across the lifespan (Paul et al., 2006). In addition, we expect that loneliness differences in physiological reserves will be evident primarily in precursors to disease in younger adults (e.g., alterations in physiological functioning that may indicate subclinical disease processes), whereas loneliness related influences on slowly progressing physiological disease processes will eventually manifest as frank disease and dysregulation across multiple physiological systems in older adults (Paul et al., 2006).

Loneliness, aging, health and resilience in the elderly

The accrual of loneliness effects with age is well illustrated in a recent longitudinal study (Caspi et al., 2006). In this study, social isolation in childhood and feelings of loneliness in adolescence and young adulthood predicted how many cardiovascular risk factors (e.g., body mass index, waist circumference, blood pressure, cholesterol) were elevated in young adulthood. Moreover, the number of developmental occasions (i.e., childhood, adolescence, young adulthood) at which participants were lonely predicted the number of elevated risk factors in young adulthood. These data suggest that the effects of loneliness accrue in a dose-response fashion to accelerate the rate of physiological decline.

If loneliness effects accrue across the lifespan, then we might see age differences in the relative importance and/or potency of causal pathways through which loneliness acts to diminish resilience (Gattan et al., 2005). Poor health behaviors are appealing mechanistic candidates for associations between loneliness and health. High-calorie, high fat diets and sedentary lifestyles, for example, contribute to being overweight or obese, major risk factors for disease in all societies. Research has also shown that smoking in old age is more prevalent in the lonely group than it was in the non-lonely group (Lauder et al., 2006). Stress appraisals and threat perceptions are associated with patterns of physiological activity that work to the detriment of physiological resilience and health and may therefore contribute to accelerated physiological decline with age in lonely individuals (Lauder et al., 2006). Lonely individuals also employ different coping strategies than non-lonely individuals do. Loneliness was inversely associated with active coping, seeking emotional support, and seeking instrumental support, and was positively associated with behavioral withdrawal i.e., the tendency to "give up" or "quit trying" to deal with a stressor (Cacioppo et al., 2000). Lonely individuals again were found to be less likely to seek emotional support and more likely to report behavioral withdrawal (Hawkley et al., 2007) coping styles that tend to perpetuate stress. In addition, lonely individuals may employ qualitatively different behavioral coping strategies with increasing age. Loneliness has been associated with a higher probability of membership in a religious group but to what extent religious affiliation is an effective coping strategy for lonely individuals in older age remains to be determined (Hawkley et al., 2007).

Loneliness and changes in physiology

Age differences in the manifestations of loneliness are most apparent in physiology. In young adults, homeostatic processes are generally effective in regulating physiological endpoints within a normal range, but persistent situational demands, real or perceived (e.g., acute or chronic stress, feelings of loneliness), can result in resetting of homeostatic regulatory mechanisms to new operating levels (Sterling & Eyer, 1981). These changes in physiology signal risk for disease and can be evident early in life (Caspi et al., 2006). Lonely young and old adults exhibit higher levels of total peripheral blood vessel resistance than non-lonely individuals do, but levels of systolic blood pressure (SBP) do not differ as a function of loneliness (Cacioppo et al., 2002; Hawkley et al., 2003).

Physical and psychological stressors activate the sympathetic adrenomedullary system and the hypothalamic-pituitary-adrenocortical (HPA) axis, physiological pathways that may contribute to loneliness differences in resilience. In middleaged and older adults, loneliness was associated with significantly greater urinary epinephrine excretion in an overnight urine sample (Hawkley et al., 2006). Higher levels of overnight urinary epinephrine reflect higher blood levels of circulating epinephrine and indicate greater activation of the sympathetic adrenomedullary system in lonely than nonlonely adults, consistent with greater loneliness-related wear and tear of this physiological system with age. Impairments in HPA regulation starting across the adult years could play a particularly important role in the development of glucocorticoid insensitivity (a compromising of the normal feedback mechanism in which increasing levels of cortisol turn off the release of yet more cortisol) and impairments in the regulation of inflammatory processes, thereby accelerating the rate of decline in physiological resilience among lonely individuals.

Critical issues in the epidemiology of loneliness

Questions of quality of life in late life have been dominated by health issues (Walker and Mollenkopf, 2007). Concerns about the costs of an ageing population, and concerns about how older adults can continue to be self-reliant so as not to be dependent on services have immediate policy relevance. The lack of attention is unfortunate, given that the quality of personal relationships is one of the best predictors of health and life expectancy (Dykstra, 2007). These considerations formed the reason for focusing on older adult loneliness.

We have reviewed the research literature to determine whether findings from empirical studies contradict or support three commonly held assumptions about older adult loneliness. The first, namely that loneliness is a problem specifically for older people finds only partial support. Loneliness is common only among the very old, that is, those aged 80 and over. Loneliness levels show little variation across midlife and early old age, whereas young adulthood is characterized by a relatively high prevalence of loneliness. Perlman (1988) has two explanations for why older adults are not as lonely a group as stereotypes suggest. The first is that the desired levels of contact might drop as rapidly as the actual level of contact. The second is that older adults might have higher ratings of the quality of their relationships. Older adults might be less lonely because they feel their social circumstances compare favorably in terms of earlier expectations or relative to peers. Abramson and Silverstein (2006) have reported that respondents who expressed a high level of anxiety about the aging process were most likely to overestimate the prevalence of loneliness experienced by older people. The authors point to a need to remind the general public that older people can still adapt well, enjoy life, and prosper in spite of the effects of aging. Hagestad and Uhlenberg (2006) argue that age segregation fosters ageist attitudes. Our societies are characterized by spatial, cultural and institutional arrangements that segregate old and young persons from each other, and restrict opportunities for individuals to form stable cross-age relationships. Residential, recreational and work settings which facilitate "mutual socialization" between young and old are essential to promoting knowledge of other age groups and reducing stereotypical judgments (Wenger & Burholt, 2004).

The second commonly held assumption is that people in individualistic societies are lonelier. Findings on cross national differences in loneliness in Europe showed progressively increasing levels from north to south. This pattern is contrary to stereotypes which tend to equate the individualism and de-familialism (Esping-Andersen, 1999) of the Scandinavian and the Continental European countries with high levels of so-

cial isolation. Though loneliness data for former communist countries are scarce, findings suggest that those countries rank highest in terms of the prevalence of loneliness. The number of studies on cross-national differences in older adult loneliness is limited. Few are based on data collections designed for comparative purposes (Adam et al., 2002). The most common procedure is to make existing data sets as comparable as possible, acknowledging the limitations. In terms of explanatory frameworks, the typical approach is to examine whether well-known determinants of loneliness such as partner status, health and quality of social interactions operate in a similar way across countries. A critical perspective on the portability of different explanatory models is required (Walker, 2005). Many questions remain. One of the challenges for cross-national comparative research on loneliness is to unravel "objective" circumstances, frames of reference, and response sets. Are older members of familialistic cultures lonelier because they are unaccustomed to fending for themselves and their lesser self-reliance makes them more vulnerable to the relationship losses that accompany old age. Do individualistic people consciously strive to avoid loneliness because privacy and optimism are highly valued in individualistic societies? Do people in former communist countries report higher levels of loneliness because a "litany of suffering" (Rokach, 2000) is a way of articulating the insecurities that the transformation to a capitalist system has brought them? These questions underscore the importance of considering people's normative orientations in the cultural context of the country in which they live. They also require supplementing large-scale data collections with in-depth qualitative analyses and an insider's analysis of discursive practices in the various countries (Dykstra, 2009).

The third commonly held assumption is that loneliness has increased over time. Findings showed the opposite trend: levels of loneliness have been decreasing over time, albeit slightly, or they have remained unchanged, depending on the studies that are considered. Loneliness is not the only outcome showing a change for the better. In so far they are available, trend data reveal that since the 1950s average happiness has increased slightly in rich nations and considerably in developing nations (Veenhoven and Hagerty, 2006). The few empirical studies that have been carried out on changes in family relationships across time fail to report a decline in contact and quality contrary to popular opinion. Greater reflexivity, which means an increased tendency for individuals to reflect actively and critically on their experiences and relationships, might be the driving force behind the decline in loneliness and the improvement in personal relationships. More generally, and thanks to the contributions of popular psychology publications, women's magazines, and talk shows, there is an increased awareness among the general public of the importance in life of personal relationships. Presumably, people both young and old are nowadays better motivated and better skilled at maintaining satisfying relationships (Allan, 2008).

Future research needs

Despite the absence of age differences in loneliness across most of the adult lifespan, associations between loneliness and health-relevant psychological and physiological processes show some age differences in type and/or strength. Research on age related changes or differences in associations between loneliness and health-related processes is limited. The rate of age related declines in physiological regulation and resilience can be modulated by perceived social connection or isolation. Long-term longitudinal research is needed to determine whether the diminution in the regulation of blood pressure is attributable to the influence of chronic loneliness. Future research is also needed to determine the extent to which chronic loneliness may have deleterious effects on other physiological regulatory systems (e.g., metabolic, neuroendocrine) as individuals age, and to determine whether such adverse effects accrue also in the domains of social and behavioural regulation. Given the aging of the population, the increases in the prevalence of social isolation, and the rising costs of health care, it is imperative that we gain a better understanding of the means by which loneliness influences health and well-being.

Conclusions

Loneliness is a significant cause of distress in old age. It is seen across races and in most nations. It is essential that we develop programmes for the mental well being of elderly focusing on methods to alleviate loneliness and give them social networks that will support them through the final phase of their lives. Loneliness needs to be researched further and effective methods need to be drawn out to prevent social isolation and geriatric depression in the elderly.

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