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Alleviating loneliness among older adults: possibilities and constraints of interventions

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Nowadays, a significant proportion of European adults aged 65 and over lives alone: never-married women and men, divorced people, widows and widowers continue living independently in one-person households. Especially in Northern and Western Europe frequent visits by siblings, children and friends are prioritised above co-residence: 'intimacy but at a distance'. However, when help is needed adults living alone have to rely on persons outside the household. Consequently, living alone may be considered as one of the major risk factors for loneliness. Other key determinants of loneliness are deteriorating health and handicaps, having no children or having children who live a long distance away, and the death of siblings and friends, resulting in smaller social networks.

Several of the determinants of loneliness, such as the death of peers, deteriorating health and financial pressures, are directly related to events in later phases of life. Therefore research into loneliness of older adults is especially important. Both professionals and volunteer organisations are involved in activities to prevent and relieve older adults' loneliness. In doing so, institutions rely on their unique intervention strategies and co-operation between institutions is virtually absent. This brings us to a crucial question: which interventions are successful in preventing and reducing loneliness of older adults and which types are not? Findlay (2003) and Cattan et al (2005) concluded that there was little evidence that interventions targeted on loneliness were successful.

This chapter discusses loneliness intervention strategies, as well as one example of concerted action. The concept, determinants and the prevalence of loneliness are presented in advance of comment on the research outcomes.

The loneliness framework

The concepts of loneliness and social isolation

Loneliness has to be differentiated from social isolation, which concerns the objective characteristics of a situation and refers to the absence of relationships with other people. The continuum of objective social isolation puts social isolation at one extreme and social participation at the other. Loneliness, however, reflects an individual's subjective evaluation of his or her social participation or social isolation and is the outcome of the cognitive evaluation of having a mismatch

between the quantity and quality of existing relationships on the one hand and relationship standards on the other (Perlman and Peplau, 1981). Drawing upon the cognitive perspective of loneliness, analyses focus on the psychological processes that mediate between participation in social networks and the experience of loneliness (Dykstra and Fokkema, 2007). The opposite of loneliness is feeling embedded.

Types of loneliness

Weiss (1973) differentiated emotional loneliness related to the absence of an intimate figure (spouse, best friend) and social loneliness related to the absence of a broader, engaging social network (friends, colleagues, neighbours). In general, intense loneliness is related more to emotional than to social loneliness, while the combination of both places people at risk

Table 6 Items of the 11-item (original) and the 6-item (short) De Jong Gierveld loneliness scales

Please indicate for each of the statements, the extent to which they apply to your situation, the way you feel now. Please circle the appropriate answer.

Statement:		Emotional subscale Original	Social subscale Original	Emotional subscale Short	Social subscale Short
1	There is always someone I can talk to about my day-to-day problems		◆		
2	I miss having a really close friend	◆			
3	I experience a general sense of emptiness	◆		◆	
4	There are plenty of people I can rely on when I have problems		◆		◆
5	I miss the pleasure of the company of others	◆			
6	I find my circle of friends and acquaintances too limited	◆			
7	There are many people I can trust completely		◆		◆
8	There are enough people I feel close to		◆		◆
9	I miss having people around	◆		◆	
10	I often feel rejected	◆		◆	
11	I can call on my friends whenever I need them		◆		

Note Possible answers are 'yes!', 'yes', 'more or less', 'no', 'no!'. When face-to-face interviews or telephone interviews are conducted, it may be sufficient to offer the respondents only the answers 'yes', 'more or less' and 'no'. The model is based on the so-called cognitive theoretical approach to loneliness. This approach to loneliness places emphasis on the discrepancy between what one wants in terms of interpersonal affection and intimacy and what one has; the greater the discrepancy, the greater the loneliness. In developing the scale, item response models Rasch and Mokken (MSP) were applied to evaluate the homogeneity of the scale. Scale scores are based on dichotomous item scores; the answer 'more or less' always indicates loneliness. The score 0 refers to complete social embeddedness and the absence of loneliness. The score 11 refers to ultimate loneliness.

Processing the scale data entails counting the neutral and positive answers ('more or less', 'yes', or 'yes!') on items 2, 3, 5, 6, 9, 10. This is the emotional loneliness score. The emotional loneliness score is valid only if the missing emotional loneliness score (i.e. no answer) equals 0. Count the neutral and negative ('no!', 'no', or 'more or less') answers on items 1, 4, 7, 8, 11. This is the social loneliness score. The social loneliness score is valid only if the missing social loneliness score equals 0. Compute the total loneliness score by taking the sum of the emotional loneliness score and the social loneliness score. The total loneliness score is valid only if the sum of the missing emotional loneliness score and the missing social loneliness score equals 0 or 1. Further details and updates are available at http://www.scw.vu.nl/~tilburg/

Source: J. de Jong Gierveld and T. van Tilburg (2006). A six-item scale for overall, emotional and social loneliness: confirmatory tests on survey data. *Research on Aging*, 28, 582–98

of intense, despairing loneliness. Another differentiation is between short-term and long-term, sometimes hopeless, loneliness. The types of loneliness being addressed need to be recognised in any development of loneliness interventions.

Determinants of loneliness

Many factors, including income, physical and mental health and living in isolated rural areas, are associated with the size, composition and perceived quality of one's social network, and with loneliness (Cacioppo et al, 2006; De Jong Gierveld et al, 2006; Hawkley et al, 2008; Van Tilburg, 1998; Victor et al, 2005; Wenger and Burholt, 2004). Additionally, macro-level correlates of loneliness are important: the social norms and values regarding filial obligations (countries differ, for example, in prioritising co-residence of older persons or living independently), and the patterning of economic resources contributing to social integration or exclusion (Scharf, and De Jong Gierveld, 2008).

Measuring loneliness

Loneliness has a negative connotation and hence people tend to deny being lonely. The use of direct questions including the word 'loneliness' is likely to result in underreporting and for that reason the use of a loneliness scale without references to loneliness is recommended (Pinquart and Sörensen, 2001). Two well-known loneliness scales that have no explicit references to loneliness have been used in many research projects: the UCLA loneliness scale (Russell et al, 1980) and the De Jong Gierveld loneliness scale (De Jong Gierveld and Van Tilburg, 2006). The second scale can be used as a one-dimensional loneliness measure, but researchers can also choose to use two subscales, one for emotional and one for social loneliness.

The prevalence of loneliness

On the basis of interviews in the Netherlands and the UK, it is estimated that about 20 per cent of the older population is mildly lonely and another 8–10 per cent

is intensely lonely (Victor, 2005). Intense loneliness appears to be more prevalent among divorcees, (recently) widowed people, those living alone, those confronted with deteriorating health, and individuals in deprived areas (Hawkley et al, 2008).

Alleviating loneliness

Most researchers into loneliness differentiate three main ways to reduce loneliness:

- reducing the perceived discrepancy between actual and desired relationships by increasing the number and quality of the relationships to the desired level

- reducing the perceived discrepancy by decreasing the standards held for relationships to the level of reality

- reducing the perceived discrepancy by reducing the effect of the discrepancy, e.g. by accepting these feelings or by seeing loneliness in perspective.

In general, older adults are prepared to cope with loneliness – such as by enlarging their network of personal relationships with new acquaintances and friends or by improving the quality of already existing relationships. An example: immediately after the deaths of their partners 60 per cent of widows and widowers were shown to be lonely. Thanks to efforts of the widowed persons themselves and the support of children, friends and neighbours in the period following the death of the partner, loneliness decreased to a certain extent: nine months after bereavement about 40 per cent of widowed women and men were still lonely, but 20 per cent succeeded in recovering from loneliness.

In cases of severe loneliness and a small or not optimally functioning personal network, or in cases of severe handicaps and chronic illness, others are needed to provide support and guidance to overcome loneliness. Volunteer organisations are the first to step in. Members of churches and members of neighbourhood volunteer organisations arrange regular visits to

sick and disabled adults in their homes, or organise meetings where lonely people can meet other people. Additionally, many professional interventions have been oriented towards reaching and motivating older adults to participate in community therapeutic settings in order to decrease loneliness.

Loneliness interventions

The effectiveness of loneliness interventions is unknown, with only a few exceptions (Stevens et al, 2006). In this context, the Sluyterman van Loo foundation, a Dutch welfare organisation for older people, asked researchers to investigate the effectiveness of 18 interventions (Fokkema and Van Tilburg, 2006). Half of the interventions were oriented towards an individual approach such as visiting lonely adults in their homes, and the other half involved group-oriented approaches, such as courses and group activities in nursing homes.

The resulting measurement of the effects clearly showed that no more than two projects succeeded in their mission. The first project, Esc@pe, was designed to reconnect chronically ill people with society via the internet (Fokkema and Knipscheer, 2007). The second project aimed to promote friendly contacts between residents of an assisted living complex via small-scale group activities such as meeting each other at coffee time and participation in discussion groups (Fokkema and Van Tilburg, 2006).

Semi-structured interviews were organised with project leaders, field workers and participants to find out more about the intervention processes. The overall conclusions of the researchers encompassed, among many others, the following:

- in starting the interventions, organisations failed to thoroughly examine the loneliness problem – asking, for example, to what extent people suffered from feelings of emotional and social loneliness and which factors gave rise to this situation

- in most cases a careful weighing of pros and cons of the planned intervention did not take place; only one possible intervention was considered

- in planning and organising the interventions, project leaders did not profit from the knowledge of interventions as available in other organisations

- interventions were almost exclusively oriented towards broadening the social network of the participants and, hence, were predominantly oriented towards alleviating social loneliness.

The researchers concluded that most volunteer organisations and professionals were too optimistic regarding the possibilities of successfully addressing loneliness.

A Dutch example of concerted action

Recognising the difficulties and constraints for loneliness interventions, and that the ultimate goal is the improvement of well-being of older adults, the challenge is to facilitate organisations in upgrading their loneliness intervention strategies, while fully respecting the mission of each of these organisations. Thorough preparation is needed prior to interventions, and optimal coherence should be facilitated between causes and types of loneliness on the one hand and, on the other, the type of intervention selected to support older lonely adults.

In this context it is worth mentioning the activities of the Netherlands' Coalition 'Erbij', the National Coalition against Loneliness. Recognising the scale of loneliness in society, 14 welfare organisations and companies involved in the problem have joined Coalition 'Erbij' in an attempt to tackle loneliness decisively.

Coalition Erbij* intends to prevent and alleviate loneliness by (among other things):

- increasing the awareness, knowledge and understanding of the Dutch population about loneliness. An anti-loneliness week was launched in September 2010 to raise awareness among men and women, young and old, about the risks of loneliness, the taboo of loneliness and the ways to overcome these pitfalls. Many journalists and radio stations and several TV companies paid considerable attention to these activities and in discussion programmes several members of Coalition Erbij have been interviewed to raise their voices against loneliness

- increasing knowledge and commitment of Dutch policy-makers at both the national and the local level. Disclosure of recent research into the incidence of loneliness and stereotypical views of it has been presented to representatives of the government. The representatives have been offered the opportunity to express their voices publicly, via TV, to promote policies aimed at alleviating loneliness

- as a coalition, incorporating large numbers of professional workers and volunteers, co-operating closely with each other and using every possibility to learn from experiences of other organisations. In this context it is worth mentioning that the effectiveness of four loneliness interventions is under investigation at this moment. Members of the Coalition will be informed about the outcomes of the intervention research and will discuss the outcomes in the light of a future work plan.

In doing so, the constituent members of the Netherlands' National Coalition Erbij will be in an optimal position to guarantee that their actions addressing a wider audience, as well as policy-makers at national and local levels, will impact on the prevention and alleviation of loneliness among the older population.

*The word 'Erbij' can be translated as connected or included. In this coalition participate, among others: Sunflower Foundation (40,000 volunteers provide adults who have physical handicaps and are at risk of loneliness with possibilities to contact others, either via home visits or day activities and holidays), Humanitas (Dutch association for social services and community structure), Salvation Army, Mezzo (Dutch Association for Carers and Voluntary Help), Dutch Council of the Chronically Ill and Disabled (the umbrella organisation, consisting of associations of people with a chronic illness or disability), Sensoor (providing confidential attention 24 hours per day), the Netherlands Foundation of Mental Health, the National Elderly Foundation, the Council of Churches in the Netherlands, FORUM, ANGO (the Netherlands Organisation of Disabled People) and KPMG ('Erbij' was started on the initiative of the director Corporate Social Responsibility of KPMG, Jan Van den Herik).