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Older People's Experiences of Loneliness in the UK: Does Gender Matter?

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The extent and nature of loneliness in later life does not show a consistent relationship with gender. Our study investigates whether there are differences in the nature and extent of loneliness amongst older men and women in contemporary Britain.

Loneliness was measured using a self-report four-point scale in a nationally representative survey of people aged 65+ living in the community.

Survey response rate was 77 per cent and the sample of 999 approximates to that of the general population. Approximately half of our sample 53 per cent were women. Compared with males in the sample women were significantly more likely to be widowed, live alone and have direct contact with friends and relatives. Preliminary analysis identified statistically significant differences between men and women in and self-reported loneliness (and changes over the previous decade). Ordered logistic regression, indicated that gender was no longer independently associated with loneliness once the confounding influences of marital status, age and living arrangement were excluded.

The overall self-reported prevalence of severe loneliness shows little difference between men and women, challenging the stereotype that loneliness is a specifically female experience.

Introduction

Research studies have consistently demonstrated a relationship between social engagement and participation and 'quality of life' in old age (Bond and Corner, 2004). This relationship is exemplified by the thesis, of 'successful ageing' advanced by Rowe and Kahn (1997). They argue that the social and physical context is highly influential for the experience of later life and that, in advanced age, it is more important than intrinsic genetic factors. Engagement with life, as defined by the maintenance of social relationships and productive activities, is one of the three key dimensions of their model of 'successful ageing'. This proposition draws attention to the strength of the relationship between

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quality of life and the social context within which ageing is experienced. Furthermore surveys have consistently identified the importance of family and other social relationships as central to the concept of quality of life (Bowling, 1995; Bowling *et al*., 1991, 2002). This suggests that the promotion and enhancement of social participation in later life could have benefits for the quality of life experienced by older people and be one approach to adding 'life to years', the major objective of Government social policy for older people. Indeed the current focus upon 'social inclusion' is another manifestation of this preoccupation with maintaining social engagement across the life course.

Recent interest in the influence of the 'social world' upon the experience of ageing mirrors that expressed several decades earlier in the classic studies of the social relationships of older people by Sheldon (1948), Townsend (1957, 1968) and Tunstall (1966). All of these studies examined loneliness in varying degrees as this was seen as being a factor integral to quality of life in old age (Gibson, 2001) and an exemplar of social (dis)engagement. These studies used self-report Likert scale questions with respondents rating their feelings of loneliness on a scale from never to always, with varying response categories (see Victor *et al*., 2002). The focus was upon measuring the extent of loneliness and identifying risk factors for loneliness with an implicit objective of facilitating the development of screening tools and developing interventions by which loneliness could be identified and ameliorated.

Loneliness is theoretically, conceptually and methodologically complex (de Jong Gierveld, 1998; Victor *et al*., 2000; Wenger, 1983). However it may be broadly conceptualised as the subjective evaluation of the nature, quality and quantity of an individuals' overall level of social interaction and engagement. Loneliness is the state where the individual's quantity and/or quality of social relationships is below the desired level. Loneliness itself needs to be distinguished from three related concepts: being alone (time spent alone), living alone (a description of household arrangements) and social isolation (the level of integration of individuals (and groups) into the wider social environment). Whilst these four different concepts share some commonality, the precise degree of overlap is unclear and the terms should not be used interchangeably (Victor *et al*., 2000).

As first noted by Townsend (1968) there are at least four major perspectives on loneliness; peer group focus, age-related, generational comparisons and cohort comparisons. This paper focuses upon the first two approaches. Peer group studies consider the prevalence and distribution of loneliness within a given population and seeks to identify groups especially vulnerable to the experience. One important element of this body of work has been the identification of a set of classic risk factors including sociodemographic factors (living alone, being female, not having any surviving children, being aged 75 years and over), material circumstances (poverty and low income), health status (including disability, self-assessed health, mental health an depression) and life events (recent bereavement an admission of a relative/spouse into care) (Victor *et al*., 2000). However, there has been little examination, until recently, of the factors that may protect against loneliness in later life (see Victor *et al*. 2005).

In considering the specific groups considered most at risk of experiencing loneliness the evidence of a relationship with gender is conflicting. Within the United Kingdom, Sheldon (1948), in his pioneering study, noted that 9 per cent of men and 7 per cent of women reported that they were often lonely. Townsend (1957, 1968) and Tunstall (1966), in contrast, report the opposite pattern with women reporting slightly higher

levels of severe loneliness; a pattern confirmed by the more recent study of Prince *et al*. (1997) who report that 19 per cent of women and 12 per cent of men in their sample experienced loneliness. If we examine the gender distribution of those describing themselves as 'sometimes' lonely then there is a clear predominance of women. Two multivariate model based studies undertaken in North Wales (Wenger *et al*., 1966) and Georgia, USA (Fees *et al*., 1999) failed to demonstrate a relationship between loneliness and gender once other factors such as widowhood and chronic disease were taken into account. In a more recent meta-analysis, Pinquet and Sorenson (2001) have suggested that loneliness is more common amongst older women than men and this may be associated with the greater losses such widowhood or severe health problems in a spouse that older women may experience.

The necessity to incorporate a lifecourse approach to loneliness was first argued by Townsend (1968) and De Jong Giervald (1988) also notes the importance of the temporal dimension. Age-related studies compare current levels of loneliness with those for the same individuals but at younger ages. Drawing upon this lifecourse perspective to loneliness we suggest that there may be two distinct forms of loneliness in later life: those older people for whom loneliness is a continuation of a previous way of life and those for whom it is a new experience. The former group we characterise as demonstrating lifelong loneliness and the later as late onset loneliness (see Victor *et al*., 2004 for further discussion of this typology).

Using data from a project examining loneliness, social isolation and living alone in later life, funded as part of the ESRC Growing Older (GO) programme, this paper presents a secondary analysis of peer group and age-related patterns of loneliness amongst a contemporary cohort of older people with specific reference to gender. In particular we wish to examine the widespread stereotype that loneliness is a problem specific to older women.

Methodology

The survey was conducted in 2001 using the Office for National Statistics Omnibus Survey, a direct interview conducted with approximately 2,000 adults aged 16+ in the community undertaken monthly or bi-monthly. Our sample is based on four monthly data collection sweeps across the twelve months from April 2000 to March 2001 to eliminate seasonal variations. Full details of the sample and methodology employed in this study are available elsewhere (Bowling *et al*., 2002; Ayis *et al*., 2003; Victor *et al*., 2005).

There are two main approaches towards the quantitative measurement of loneliness; the use of direct self-report scales and composite scales such as those devised by Wenger (1984) and De Jong-Giervald (1987). Each approach has merit. As a prime objective of our Growing Older Programme project was to make direct comparison with the established post-war UK studies of loneliness, thereby facilitating examination of cohort changes in loneliness, we measured loneliness using a 4 point self-rating scale ranging from always lonely to never lonely (see Sheldon, 1948; Tunstall, 1966; Wenger, 1983). However this approach is problematic conceptually because it presuposes a shared understanding of the term loneliness and methodologically because older people may find this question stigmatising as, in presenting a public face in an interview setting, they may not wish to compromise their own (and the interviewer's) notions of their self-worth by admitting

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to feelings of loneliness. Holmen and Furukawa (2002) argue that this type of measure is more appropriate for use with older people than the more complex scales and it is a measure which is both acceptable to older people and immediately understood by them. Age-related loneliness was measured using a question inviting respondents to compare current level of loneliness with that of a decade earlier and evaluate themselves as better, worse, unchanged. Standard demographic and other data were also collected (see Bowling *et al*., 2002; Ayis, 2003; Victor *et al*., 2004, 2005 for a description of the full range of data collected).

The Chi square test was used to consider patterns of association between loneliness and specific factors in a preliminary univariate analysis. In addition odds ratios and 95 per cent confidence intervals were also calculated for each risk factor. Individual risk factors were grouped into five theoretical defined blocks: socio-demographic factors, health resources, material resources, social resources and social network (see Victor *et al*., 2005). Here we present the results of the socio-demographic factors – age, marital status, household composition and gender. Ordered logistic regression was used to test the independence of association between gender and our dependent outcome variable (loneliness). For this analysis loneliness was grouped into three categories – always/often, sometimes and never – rather than a dichotomous division as this neither reflected the complexity of this phenomena and did not give due importance to the intermediate loneliness category. Within each block of variables, likelihood ratio tests were used to determine which variable in combination were significant, and removing them one by one till the best model was achieved (i.e. backwards elimination of variables).

Results

The results are presented in two sections: (a) response rates and the characteristics of the samples and (b) prevalence of loneliness and the examination of gender differences.

(a) Study response rate and the characteristics of the samples

Overall 1,323 addresses were identified as eligible for inclusion in our study (i.e. the address contained a person aged 65+ who had given consent to participation in our survey). At follow-up, 24 of these addresses were subsequently found to be ineligible, leaving a potential study population of 1,299: 243 refused (19 per cent) and 57 were not contactable (4 per cent), giving a study population of 999 respondents and a response rate of 77 per cent.

Our sample approximates to the general population of older people living in the community, although we have significantly more widows (39 per cent compared with 33 per cent) and slightly fewer women (53 per cent compared with 57 per cent). Extrapolating from previous research the over-representation of widow(ers) would bias rates of loneliness upward. Rates of chronic illness approximate to national norms as do levels of social engagement (Table 1).

Comparison of the characteristics of the men and women in the sample reveals similarity of experience in terms of the age profile and health status (Table 1). Women were significantly more likely than men to be living alone (22 per cent of men and 41 per cent of women) or widowed (15 per cent of men were widowed compared with 41 per cent of

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Table 1 Characteristics of sample and comparison of males and females (per cent)

	GB 2001 #	GO SURVEY	Male	Females
SOCIO DEMOGRAPHIC				
Lives alone	37	37	22**	41
Female	57	53		
Age 75+	42	42	37	38
Widowed	33	39*	15**	41
Home owner	68	72		
HEALTH STATUS				
Health rated v. good			38	41
Longstanding illness	61	62	60	64
Problems with sight	27	24	20	27
Problems with hearing	41	36	42*	29
SOCIAL CONTACT				
No living children			13	14
No living siblings			26	29
Out of house in previous week			98	97
Social activity in previous month			95	92
Direct contact with relatives in previous week	66	62	59	65**
Phone contact with relatives in previous week	85	81	75	88**
Direct contact with friends in last week	70	71	72	71
Phone contact with friends in previous week	67	64	60	70**
Contact with neighbours in last week	88	89	91	86**
Always/often/sometimes lonely			32	52**
Less lonely than 10 years previous		10	8	12**
More lonely than 10 years ago		23	17	28
Loneliness unchanged		68	75	60

Notes: # GB population date derived from 2001 General Household Survey and excludes those not living in the community.
* Differences between GB and study population statistically at 5 per cent using chi square.
** Differences between men and women statistically significant at 5 per cent using chi square.

women). Women also had significantly higher levels of contact with family, friends and neighbours. Consequently any observed differences in rates of loneliness do not reflect significant differences between the two groups in terms of health but may be linked to the differentials in social resources, marital status or household living arrangements, all variables that have been reported in the literature as having a statistically significant relationship with loneliness.

(b) Prevalence of loneliness and gender differences

The majority of participants, 61 per cent, rated themselves as never lonely, 31 per cent as sometimes lonely, 5 per cent as often lonely and 2 per cent as always lonely. For those who considered that they were always lonely there was no difference between men and women with 2 per cent defining themselves in this category. However, significantly more women (45 per cent) than men (28 per cent) reported that they were sometimes (table 2) lonely.

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Table 2 Prevalence of loneliness by gender in selected British studies

	Always/often		Sometimes		Never	
	M	F	M	F	M	F
Sheldon 1948	10	7	6	16	84	76
Townsend 1968	5	8	51	26	81	66
Wenger 1984*	5	11	26	31	69	58
Jones *et al.* 1985	2	5	10	20	88	75
GO SURVEY 2001	6	7	28	45	66	48

Note: * Based upon composite measure rather than self-report question.

We invited participants to evaluate how their levels of loneliness had changed over the previous decade. Approximately two-thirds, 68 per cent, reported that their loneliness rating had not changed in the previous decade, whilst 23 per cent reported that it had deteriorated (Table 1). However, change was not always universally for the worse, as 10 per cent of participants rated themselves as less lonely than a decade previous. Women were significantly more likely than men to report that they were either less lonely than ten years previously (12 per cent compared with 8 per cent) or lonelier (28 per cent compared with 17 per cent), whilst men were more likely to rate themselves as unchanged (75 per cent compared with 60 per cent of women).

At the level of analysis where we consider gender isolation from other factors there is a strong and highly statistically significant relationship between gender and loneliness, (see Table 2), which stems from the large differences between men and women in the percentage rating themselves as sometimes lonely. This is confirmed by the calculation of the crude odds ratio for loneliness for women which was 2.03 (confidence interval 1.58–2.59), suggesting that they were at elevated risk of experiencing loneliness in old age compared with their male contemporaries (Table 3). However significant relationships are also demonstrated between loneliness and the other key demographic variables. The 'oldest old', those living alone and the non-married, all demonstrating significantly elevated risk of experiencing loneliness in later life in comparison to married elders, 'younger' elders and those living in households of two or more persons.

We sought to establish if gender is independently linked to loneliness or if this relationship is confounded by the higher rates of widowhood or solo living illustrated by older women as compared with their male contemporaries (see Victor *et al*., 2005 for a more detailed discussion of the overall model). The ordered logistic regression indicates that, once differences in marital status, age and household size were taken into account, gender did not demonstrate an independent relationship with loneliness (odds ratio of 1.15, confidence interval 0.87 to 1.51). Of the socio-demographic factors, it is widowhood that massively increases the vulnerability of older people to loneliness. Gender does not demonstrate an independent relationship once the effect of these other factors is taken into account.

Discussion

Loneliness is still conceptualised by many, including older people themselves, as being a problem which is specific to old age despite the evidence that other groups within

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Table 3 Loneliness and relationship with demographic factors

Demographic factors		% Lonely			Unadjusted		Adjusted (for age, marital status and household composition)	
Age	*N*	Always/ often	Some-times	Never	Odds ratio	C.I.	Odds ration	C.I.
65–74	582	6	38	55	1		1	
75–84	343	13	38	49	1.40	1.08–1.8	0.81	0.6–1.09
85+	72	18*	24	58	1.12	0.68	0.47	0.27–0.83
Sex								
Male	474	6	28	66	1		1	
Female	523	7*	45	48	2.03	1.58–2.59	1.15	0.87–1.51
House-hold Status								
Lives alone	467	17*	51	31	1		1	
Lives with others	532	2	24	75	0.16	0.12–0.21	0.53	0.33–0.85
Marital Status								
Widowed	386	20*	53	28	9.78	7.17–13.2	6.06	**3.59–10.25**
Married	460	1	21	78	1		1.0	
Single	79	9	45	46	4.11	2.56–6.69	2.41	**1.28–4.51**
Divorced	72	8	45	46	4.02	1.86–6.62	2.36	**1.26–4.41**

the population, such as those aged 20–49, children and adolescents, are also likely to experience this state (Ellaway *et al*., 1999; Sogaard *et al*., 1996; Cheng and Furnham, 2002). Our survey is consistent with previous research in that only a minority, 7 per cent, reported that they were often/always lonely. These findings are remarkably similar to those reported in a general population survey of people in Queensland (6.1 per cent reported severe loneliness) (Lauder *et al*., 2004) and in a survey of people 65 years and over in Perth, Western Australia (7 per cent reported severe loneliness) (Iredell *et al*., 2003). Interestingly, both these surveys were administered by post and used a self-report questionnaire hinting that responses do not vary substantially with the method used to collect the data within the context of a structured questionnaire. This stability in the public account of loneliness across the studies is of note given that the samples studied by Sheldon (1948), Tunstall (1966), Townsend (1957, 1968) were predominantly female in composition: approximately 70 per cent compared with about half of those participating in the current study. Old age has always been presented as a predominantly female experience. Until recently this has been the case. However as we can see from the extrapolation of current trends, future cohorts of older people are likely to demonstrate a more equal gender balance. Hence we need to ensure that our research and policy agendas and interventions reflect the dynamic nature of the older population and include both older men and women.

In contrast to previous research, our participants were more likely to report that they were sometimes lonely. Almost a third of participants were in this group, which is much greater than the 11–22 per cent reported in previous research (Sheldon, 1948; Townsend, 1957) and mirrors the results from our recent pilot survey (Victor *et al*., 2002) and offers clear evidence of a secular trend for both men and women. This observation may reflect

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changes in the meaning of the question and rating categories over time, a change in how older people evaluate their levels of social engagement or a change in the willingness of older people to report that they experience loneliness with all the perceived stigma that such a public admission might bring.

Our univariate analysis highlighted that, as in many previous studies, women were more vulnerable to reporting feelings of loneliness than men. Indeed 60 per cent of those who were lonely were women, which is not too dissimilar to the 70 per cent reported by Sheldon almost 60 years earlier (1948). This differential is most evident in the intermediate, sometimes, lonely category, with a male: female differential of approximately 1:2. There are several explanations for this observation. First it could be the case that older women are more likely to experience loneliness than their male contemporaries. Second these findings may be an artefact of the methodology employed. The self-report measures used in this and most British studies may under-report loneliness amongst men as they may be less likely to present a public account of loneliness and that for men indirect scales or in-depth qualitative projects may be more appropriate methods for collecting these types of data. Clearly this is an area for further research. Comparisons of the use of aggregate measures such as the de Jong scale (de Jong Gierveld, 1987) or more anonymous methods of data collection such as postal or self-completion questions may help to clarify the extent of loneliness amongst both older men and women and establish the similarities and differences. However gender is linked with other factors, such as age, marital status and household size, and our observation of higher reported rates of loneliness amongst women than men may reflect the differential distribution of these factors between the sexes. In our sample, women were significantly more likely to live alone and to be widowed than their male counterparts. When we take into account these factors, gender is not independently related to loneliness. From a socio-demographic perspective, the key factor associated with vulnerability to loneliness is marital status. Those who are married are at substantially less risk of experiencing loneliness than the single, divorced or widowed. This indicates that loneliness is an issue for all older people and that men are as vulnerable to this experience as women (Tijhuis *et al*., 1999).

Townsend (1968) argued for the incorporation of a lifecourse perspective into the study of loneliness in later life. There have been some longitudinal studies (see Holman and Furukawa, 2002; Tijhuis *et al*., 1999; Wenger and Burholt, 2004) but little overt adoption of a lifecourse approach. Our study demonstrates that for 28 per cent of men and 17 per cent of women feelings of loneliness had increased over the previous decade and for 12 per cent and 8 per cent respectively they had decreased. This highlights the dynamic nature of loneliness in later life and serves to highlight the limitations inherent in the cross-sectional approach and there is clearly more scope for developing a lifecourse approach to the study of loneliness.

Loneliness amongst older men and women clearly compromises their quality of life. However it does have a much wider public health impact as loneliness is associated with a variety of negative health outcomes, including mortality (Berkman and Syme, 1979; House *et al*., 1982; Cacioppo *et al*., 2002), morbidity (Cacioppo *et al*., 2002; Sorkin *et al*., 2002), depression (Heikkinen *et al*., 2002) and suicide (Waern *et al*., 2003) as well as health service use (Geller *et al*., 1999; Ellaway *et al*., 1999). Although the mechanisms underpinning such relationships are unclear (Hawkley and Cacioppo, 2003), policy and practice interventions to promote social engagement in later life are an important element in social and health policy for older people. The social environment is one of the key

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factors determining quality of life in old age. Research has consistently demonstrated a strong and positive relationship between social engagement in all forms, but especially participation within kin and wider social networks, and a high quality of life. Older people consistently report that the social environment, especially social relationships with members of their family, is fundamental to notions of quality of life in old age (Bowling, 1995). However, this recognition of the importance of this relationship is not new. In the early 1960s the activity theorists of ageing posited that the key to a good old age was the maintenance of kin- and friendship-based relationships. This resonates with the ideas of Rowe and Kahn (1997) who suggest that a high level of social engagement is a key factor in achieving the goal of 'successful ageing'. Whilst the prescriptive strictures of activity theory and successful ageing remain the subject of debate, the social environment continues to exert an important influence upon and context within which people experience old age (Bowling *et al*., 1991).

A key element of current thinking concerning the promotion of quality of life in old age relates to notions of social engagement and social inclusion. Manipulation of the social environment by, for example, interventions to promote social engagement and combat loneliness and isolation, may offer pathways for the improvement and enhancement of quality of life in old age; currently a key policy objective for older people. Consequently there is a concern to promote social engagement amongst older people that is manifest in local and national policy makers' interests in concepts such as social capital and social exclusion. However, like the concept of community care, notions of social capital and social exclusion manifest many different conceptualisations, with a variety of different terms and concepts being used interchangeably (Scharf *et al*., 2000, 2002). Social engagement is a broad and diverse concept with different subdivisions relating to notions such as social capital and social participation, as measured by activity and contract rates, and social networks, which include notions of exchange relationships, intimate ties and roles and relationships. The predominant conceptualisation of exclusion in terms of social relationships in later life has been in terms of investigating the pathological end of the distribution, with a specific concentration upon isolation and loneliness. This largely reflects an approach to the investigation of social relationships in later life influenced by the study of social problems and, perhaps, too ready an acceptance of the stereotype that the normal experience of old age is of social neglect, isolation and a reliance upon fragile social networks.

Less attention has been given to determining what protects older people against loneliness, although this is clearly key to developing appropriate and effective interventions. Promoting engagement and combating loneliness (and isolation) is an important policy goal both nationally and locally (and probably internationally). Interventions to alleviate loneliness and isolation may take place in a variety of formats, and demonstrate substantial variability in terms of the level at which they operate (community, group or individual), the location (home or external setting) and whether they are concentrated exclusively upon social relationships or adopt a wider remit. Cattan *et al*. (2003, 2005) and Findlay (2003) have undertaken a systematic review of studies undertaken within this area and conclude that interventions targeted at specific groups (e.g. women or caregivers) undertaken in group settings showed some evidence of effectiveness, whilst those that were one to one and conducted in people's own homes showed no evidence of effectiveness. However it remains unclear as to what it is about the group schemes that make them effective; nor do we know what else does (or does not) work (Catten *et al*., 2003) and how such schemes

may differentially benefit specific groups of older people. By utilisation of multivariate statistical methods our study suggests that loneliness in later life is as much an issue for men as women and that this needs to be recognised when developing both the research agenda and in considering interventions to promote social participation in later life.

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