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Predictors of Loneliness in U.S. Adults Over Age Sixty-Five

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The purpose of this study was to examine sociodemographic and health-related risks for loneliness among older adults using Health and Retirement Study Data. Overall prevalence of loneliness was 19.3%. Marital status, self-report of health, number of chronic illnesses, gross motor impairment, fine motor impairment, and living alone were predictors of loneliness. Age, female gender, use of home care, and frequency of healthcare visits were not predictive. Loneliness is a prevalent problem for older adults in the United States with its own health-related risks. Future research of interventions targeting identified risks would enhance the evidence base for nursing and the problem of loneliness.
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LONELINESS HAS BEEN reported as a prevalent problem and negative experience for older adults for over 50 years in the social science and healthcare literature. The prevalence of loneliness has been reported to range from 12% in older men (Berg, Mellstrom, Persson, & Svanborg, 1981) to as high as 38% in older women (Holmen, Ericsson, Andersson, & Winblad, 1992). Despite the prevalence, limited emphasis has been placed on understanding the sociodemographic or specific health-related risks for loneliness. Historically, loneliness has been conceptualized as a construct that is embedded with other problems such as depression, anger, diminished social support, or self-isolating behavior. However, recent studies indicate that loneliness is a separate psychological construct from depression (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006), making it reasonable to consider that loneliness may have its own unique risks. This research contributes to the current knowledge base on loneliness by providing evidence for sociodemographic and health-related predictors of loneliness for U.S. older adults.

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL CORRELATES OF LONELINESS

Studies using older adult samples consistently report negative physical, psychological, and social correlates of loneliness. Physical correlates have included advancing age (Holmen et al., 1992), poor perceived health (Berg et al., 1981; Holmen et al., 1992), physical symptomatology (Berg et al., 1981; Cacioppo et al., 2002), cardiovascular effects including hypertension (Andersson, 1985; Cacioppo et al., 2002; Lynch & Covey, 1979; Tomaka, Thompson, & Palacios, 2006), malnutrition (Walker & Beauchene, 1991; Wylie, Copeman, & Kirk, 1999), sleep disturbance (Berg et al., 1981), and dementia (Wilson et al., 2007). Negative psychological correlates of loneliness have included depressed mood and negative self-assessment (Berg et al., 1981), diminished intimacy in marriage (Barbour, 1993), and substance abuse (Thauberger, 1981). Paul, Aviss, and Ebrahim (2006) reported loneliness as the most important predictor of psychological distress for British older adults. Three recent studies have reported that

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loneliness is independently predictive of depression (Alpass & Neville, 2003; Cacioppo et al., 2006; Cohen-Mansfield & Parpura-Gill, 2007). Negative social correlates of loneliness have included lower economic status (Hector-Taylor & Adams, 1996), less education (Hector-Taylor & Adams, 1996), non-married status (Andersson & Stevens, 1993; Barbour, 1993), widowhood (Berg et al., 1981), living alone (Yeh & Lo, 2004), low number of social contacts (Larson, Zuzanek, & Mannell, 1985), low number of friends (Mullins & Elston, 1996), lack of religious affiliation (Fry & Debats, 2002; Rokach, 2000), and domestic violence (Lauder, Sharkey, & Mummery, 2004).

Healthcare utilization, which could be considered a marker of general health, has been reported to be increased in relation to loneliness but the current information is conflicting A study of 373 Swedish 60 year-olds reported that loneliness was associated with an almost two-fold increase in clinic visits (Ellaway, Wood, & Macintyre, 1999). Berg and colleagues (1981) reported that lonely, older women had a higher frequency of seeking healthcare than their non-lonely counterparts. In contrast, loneliness did not predict an increase in professional healthcare visits in an Australian sample (Lauder et al., 2004). Given this inconsistency and the rising costs of healthcare in the U.S., it is important to know if an increase in doctor visits is predictive of loneliness for the nation's older adults or vice versa.

PREDICTING LONELINESS

Prior studies regarding predictors of loneliness report results similar to the aforementioned correlates of loneliness. Ten prior cross-sectional studies have reported analyses of social, psychological, and physical variables for explanatory value in relation toloneliness. Social variables reported as predictors have included non-married status (Hector-Taylor & Adams, 1996; Lauder, 2004; Victor, Scambler, Bond, & Bowling, 2005), diminished social contact and time alone (Cohen-Mansfield & Parpura-Gill, 2007; Hector-Taylor & Adams, 1996; Kim, 1999; Pinquart, 2003; Tilburg, Gierveld, Leccini, & Marsiglia, 1998; Victor et al., 2005), domestic violence (Lauder et al., 2004), unemployment (Lauder et al., 2004), low education (Hector-Taylor & Adams, 1996), and low income (Cohen-Mansfield & Parpura-Gill, 2007). Physical predictors have included declining physical health (Dykstra, Van Tilburg, & De Jong Gierveld, 2005; Savikko, Routasalo, Tilvis, Strandbert, & Pitkala, 2005; Victor et al., 2005) and decline in functional status (Cohen-Mansfield & Parpura-Gill, 2007; Kim, 1999; Pinquart, 2003). Declining mental health (Victor et al., 2005), poor self-efficacy (Fry & Debats, 2002), low satisfaction with support (Kim, 1999), not belonging to a group (Hector-Taylor & Adams, 1996), and diminished ethnic attachment (Kim 1999) have been reported as psychological variables that may be explanatory of loneliness. Kim (1999) reported that non-married status was not predictive in her sample of Korean women.

PURPOSE OF THE STUDY

It is important that loneliness be studied within specific cultures since culture can profoundly affect a person's mental health (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996). Predictors of loneliness could differ based on healthcare opportunities and social programs offered within the country of residence. Further, negative health outcomes associated with loneliness may not be consistent cross-culturally. Tomaka and colleagues (2006) compared their Caucasian and Hispanic samples and reported that loneliness was more predictive of disease states in Hispanics. They also reported that belonging support was protective as a predictor for diabetes and hypertension for this group, indicating that Hispanics who feel a sense of belonging may diminish their risk for these two illnesses (Tomaka et al., 2006). The majority of quantitative studies on loneliness which have included older adult samples have been conducted outside of the United States. There is still a gap in the literature when it comes to understanding the relationship of health-related and sociodemographic variables to loneliness for older U.S. adults.

The purpose of this research was to analyze multiple sociodemographic and health-related variables as predictors of loneliness in a large, random sample of older community-dwelling U.S. adults. The research question posed for this study asks, "Are health-related and sociodemographic variables are predictive of loneliness in a U.S. sample of older adults?" Variables were chosen as predictors from the literature review of significant predictors or correlates of loneliness. It was hypothesized that participants with advancing age, female gender, widowhood, status of living alone,

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