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Loneliness of older people aged 70: A comparison of two Finnish cohorts born 20 years apart

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ABSTRACT

Objective: This study aimed to examine loneliness among two birth cohorts, born 20 years apart, when they were 70 years of age, and to identify factors explaining loneliness.
Methods: The cohorts consisted of older home-dwelling residents of Turku, Finland, from the birth cohort 1920 in 1991 ($N = 1530$) and the birth cohort 1940 in 2011 ($N = 1307$). Suffering from loneliness was assessed with the question: 'Do you suffer from loneliness?' Cross-tabulations with chi-square test, general linear model (GLM) and multiple regression analysis were used in statistical testing and modeling.
Results: In the 1940 cohort, around one-fifth (18%) of the respondents suffered from loneliness at least sometimes, while the corresponding figure in the 1920 cohort was around one-fourth (26%). Our analyses indicated that the effect of cohort was not a statistically significant explanatory factor of loneliness. Living status, self-rated health and memory compared to age peers were statistically significant explanatory factors for suffering from loneliness. When we controlled the effect of depressiveness on the experience of loneliness, it was shown that the effects of living status and self-rated health remained statistically significant, whereas memory compared to age peers did not. Depressiveness itself was highly important. The combined effect of living status and self-rated health emerged as the most significant explanatory factor for loneliness. Older people with poor self-rated health who lived alone were most likely to suffer from loneliness.
Conclusion: The findings give healthcare professionals an opportunity to plan for interventions aimed at combating loneliness among home-dwelling older people.

1. Introduction

Loneliness is a common subjective complaint among older people. Prevalence rates of loneliness in older people are high, with estimates around 25%, varying from 7% to 49% (Adams, Sanders, & Auth, 2004; Chalise, Kai, & Saito, 2010; Stek et al., 2005; Stessman, Rottenberg, Shimshilashvili, Ein-Mor, & Jacobs, 2014). All definitions of loneliness share the same conceptualization that this is a distressing feeling which has been defined as an individual's subjective experience about lack of satisfying human relationships (Andersson, 1998; Peplau & Perlman, 1982). Weiss (1973) distinguished between emotional and social loneliness. Emotional loneliness arises in situations where a reliable or intimate relationship is lacking, while social loneliness is caused by absence of social networks.

In an age characterized by a growing older population (Vaupel, 2010), a crucial public health issue is to support older people's autonomy and to help them to live in their own homes for as long as possible (WHO, 2011). Loneliness has been identified as a risk for community-dwelling older people's independent living. Loneliness in older people may lead to physical and cognitive decline (Cohen-Mansfield & Perach, 2014; Hawkley & Cacioppo, 2010; Wilson et al., 2007), reduced activity levels (Hawkley, Thisted, & Cacioppo, 2009), increased morbidity (Cucinotta, 2007; Penninx et al., 1999) and mortality (Holwerda et al., 2012; Perissinotto, Cenzer, & Covinsky, 2012; Tilvis, Laitala, Routasalo, & Pitkälä, 2011) Lonely people are also more frequent users of healthcare services (Jakobsson, Kristensson, Hallberg, & Midlöv, 2011; Molloy, McGee,

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O'Neill, & Conroy, 2010), making loneliness a costly healthcare problem.

The prevalence of loneliness increases with age (Eloranta et al., 2012; Savikko, Routasalo, Tilvis, Strandberg, & Pitkälä, 2005). This is not explained by age itself, but rather by changes and losses in health, functional capacity and social networks (Jylhä, 2004; Kirkevold, Moyle, Wilkinson, Meyer, & Hauge, 2013; Savikko et al., 2005; Victoret al., 2005). Socio-demographic, health and social factors, such as gender, low level of education, widowhood, living alone, poor subjective and objective health, depression, a weak social network, feeling of being poorly understood by close persons, and unfulfilled expectations of contacts with friends have been the most powerful explanations for suffering from loneliness (Dahlberg, Andersson, McKee, & Lennartsson, 2014; Ekwall, Sivberg, & Hallberg, 2005; Routasalo, Savikko, Tilvis, Strandberg, & Pitkälä, 2006; Savikko et al., 2005; Victor, Scambler, Bowling, & Bond, 2005; Yan et al., 2014). Loneliness has been found to be more common among older women than among older men (Savikko et al., 2005; Victor, Scambler, Bond, & Bowling, 2000). On the other hand, men experience more harmful associates of loneliness (Tilvis et al., 2011; Zebhauser et al., 2013). It has been explained that the threshold for feeling lonely is lower in women than in men, or that women admit more readily their feelings of loneliness and may have more expectations regarding satisfying social contacts (Tijhuis, De Jong-Gierveld, Feskens, & Kromhout, 1999; Tilvis et al., 2011).

It has been stated that people live longer and healthier lives than earlier generations. A recent cohort comparison report showed that later-born cohorts of 70-year-olds had higher educational level (Beckman, Waern, Gustafson, & Skoog, 2008), were healthier (Wilhelmson, Allebeck, & Steen, 2002) and had better cognitive function (Sacuiu et al., 2010) compared with earlier cohorts. Also, later-born cohorts (age 75) are more satisfied with their social contacts compared with earlier cohorts (Falk et al., 2014). No significant differences between cohorts have been detected in the experience of loneliness (Heikkinen, Kauppinen, Salo, & Suutama, 2006; Pitkälä, Valvanne, Kulp, Strandberg, & Tilvis, 2001), although there were fewer respondents in the later-born cohorts who considered themselves to be either rather lonely or very lonely (Heikkinen et al., 2006). However, there are only limited cohort comparison studies about loneliness among older people. Thus, the aim of this study is to examine loneliness among two birth cohorts, born 20 years apart, when they were 70 years of age, and to identify factors explaining loneliness.

2. Material and methods

2.1. Sample and data collection

The study population is derived from a prospective cohort study, the Turku Elderly Study. The Turku Elderly Study started in 1991 with the aim of studying health and health-related factors in older populations living in the community in Turku, Finland (population 177,000). All samples were systematically obtained, based on year of birth, from the Finnish Population register. (A detailed description of the study protocol is provided elsewhere (Arve et al., 2012; Eloranta, Arve, Isoaho, Lehtonen, & Viitanen, 2015).

In this paper, we report data from two birth cohorts, born in 1920 ($N = 1530$, $n = 1032$) and in 1940 ($N = 1307$, $n = 957$), in 1991 and in 2011, respectively. All the subjects included in the present study were aged 70 years at the time of the data collection. The same design and survey instrument were used in both years. The response rate to the mailed questionnaire was 72% in both years (Fig. 1).

2.2. Data analysis

Loneliness was the dependent variable and it was measured with the question: 'Do you suffer from loneliness?' (seldom or never/sometimes/often or always) (e.g., Eloranta et al., 2010; Routasalo, Tilvis, Kautiainen, & Pitkälä, 2009). A total loneliness score was created by scoring this question 0 ('seldom or never'), 0.5 ('sometimes') or 1 ('often or always'). A score of 0 thus represented minor experience of loneliness and 1 major experience of loneliness.

Background characteristics that were addressed in this analysis and which were available in both surveys included gender and living status (alone/with someone). Self-rated health status as an explanatory variable was measured by a 4-point Likert scale item

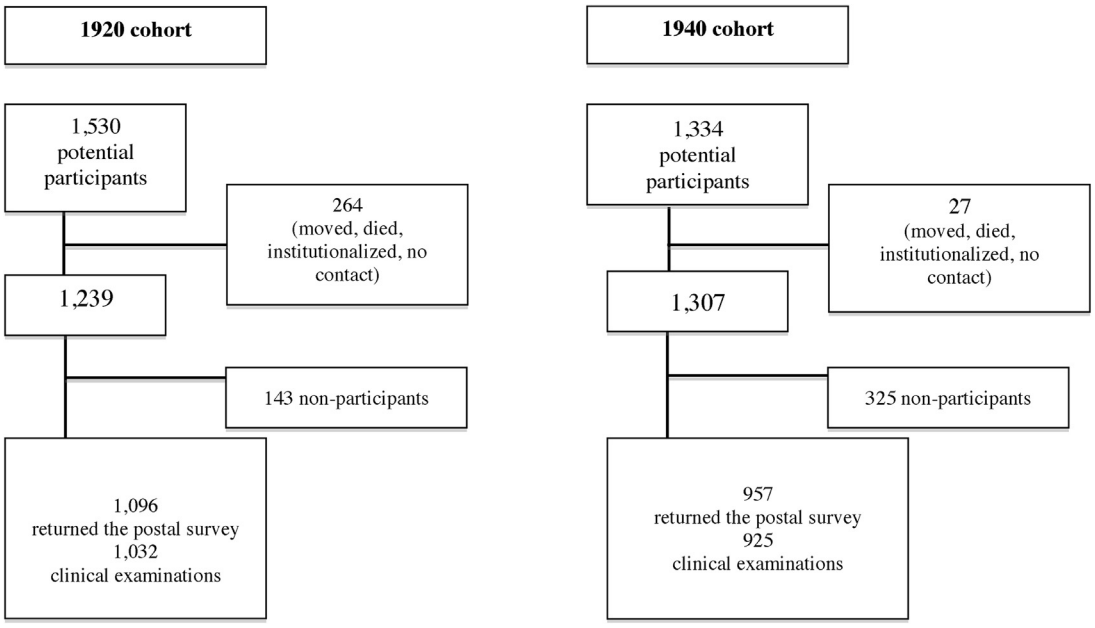

Fig. 1. The Turku elderly study, study profile for the 1920 and 1940 cohorts.