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ARTICLE

Austerity, Ageism, and the Rhetoric of Self-reliance: The Policy Drivers and Socio-cultural Attitudes Contributing to the Loneliness Experienced by Older Residents in an Underprivileged Community in South Wales

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Reducing loneliness amongst older people is an international public health and policy priority, with signs of decreasing importance in the UK. A growing body of research on tackling loneliness indicates it is a complex challenge. Most interventions imply they address loneliness, when in fact they offer social connectedness to address social isolation and can inadvertently responsibilise the individual for the causes and solutions for loneliness. This article presents research that explored loneliness in an underprivileged community in South Wales through interviews and focus groups with nineteen older people and eighteen local service providers. Their perspective supports a growing body of evidence that loneliness amongst older people is driven by wider structural and socio-cultural exclusion. Interventions to build social connections will be more effective if coupled with policies that reverse the reduction in public services (including transport and healthcare), and challenge socio-cultural norms, including a culture of self-reliance and ageism.

Keywords: Loneliness; older people; social exclusion; stigma; ageism

Introduction

The World Health Organisation's (WHO) Commission on Social Connection 2024–2026 argued that finding solutions to loneliness is an international public health and policy priority due to its negative impact on physical and mental health, well-being of communities and societies, and its association with reduced life-expectancy (Courtin and Knapp, 2017; Fried *et al.,* 2020; WHO, 2024). Recognising these negative effects, in 2018 the UK resourced a ministerial position and several commissions specifically exploring loneliness, and addressing loneliness amongst older people is a claimed priority (HM Government, 2021; NHS, 2021). Yet, despite a burgeoning body of research, particularly relating to older adults, identifying effective solutions remains a challenge because loneliness is complex, personal, and multidimensional (Prohaska *et al.*, 2020).

Most policies and interventions frame loneliness as an individual problem to be resolved through reducing isolation through increasing social connection. However, whilst they are related, isolation and loneliness are distinct concepts. Isolation refers to the objective state of having limited social contact and being physically isolated from others, whereas loneliness refers to a personal and subjective feeling that your connections are either too few and/or lack meaning

(Weiss, 1973; Wigfield *et al.,* 2022). Consequently, you can be physically isolated and not lonely, and you can be lonely whilst having an abundance of connections (Wigfield *et al.,* 2022). The perception that opportunities for increased social participation will lead to a reduction in loneliness is problematic (Oman, 2021) because there are other factors involved, including social exclusion (Walsh *et al.,* 2017; Dahlberg *et al.*, 2022).

The relationship between social exclusion and loneliness is the focus of this article, which furthers our understanding of the policies and socio-cultural attitudes that lead to increased levels of emotional, social, and existential loneliness amongst older people in deprived communities. The article presents qualitative research that explored the perceptions of drivers of loneliness with older people and service providers in an underprivileged community in South Wales. In doing so, the paper presents structural and socio-cultural strategies to overcome loneliness that may complement existing efforts to encourage social participation.

Loneliness amongst older people

Loneliness and isolation affect people of all ages, but ageing is associated with known risk factors including experiencing declining health, bereavement, living alone, retirement, and reduced mobility (Courtin and Knapp, 2017). The World Health Organisation estimates that globally up to one in four older adults is lonely (WHO, 2024). A Campaign to End Loneliness survey found similar rates in the UK where it is estimated 20 per cent of the older population is mildly lonely with another 8–10 per cent being intensely lonely. However, there is also a stereotype that old age in the UK is a particularly lonely time, which can result in ageist assumptions (Hagan, 2020). For example, stakeholders and service providers in the UK have been shown to overestimate loneliness amongst older people (Fried *et al.*, 2020). Regardless of risk or population prevalence, the negative consequences of loneliness mean that researching older people's experiences remains important (Naughton-Doe *et al.*, 2022; Victor and Pikhartova, 2020).

Loneliness

Despite their differences, loneliness and isolation are often used as catch-all terms resulting in a simplified understanding that ignores different presentations of loneliness (Smith and Victor, 2019). Loneliness is more recently conceptualised in research and policy within three domains: social, emotional, and existential (Victor *et al.,* 2022; McKenna-Plumley *et al.,* 2023). It is important to unpack these dimensions of loneliness that could identify social policies and interventions that will prevent or reduce them (Cotterell *et al.,* 2018).

Emotional loneliness refers to the absence of close meaningful relationships whereas social loneliness is the absence of a fulfilling range of social relationships (Weiss, 1973; Wigfield *et al.,* 2022). Existential loneliness, which has been less explored, refers to a fundamental sense of separation from others and the world (McKenna-Plumley *et al.,* 2023) and manifests in feelings of alienation derived from loss of purpose or identity in a society where people no longer feel valued (Bolmsjö, *et al.,* 2019; Kitzmüller *et al.*, 2018; van Tilburg, 2020). Most existential loneliness research focusses on very old and/or seriously ill individuals, but the concept is relevant across the life-course, and Victor *et al.* (2022) have argued it should be explored more in the over fifties population (Bolmsjö, *et al.,* 2019).

Individual, socio-cultural, and structural drivers of loneliness

There is an extensive quantitative literature exploring associations with, causes of, and risk factors for, isolation and loneliness (Fried *et al.*, 2020; Prohaska *et al.*, 2020), but research has rarely explored these qualitatively, nor has it explored how these causes and risk factors relate to the specific dimensions of existential, social, and emotional loneliness (Cotterell *et al.,* 2018). Most

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research into the causes of loneliness has focussed on individual drivers (micro-level factors) (Victor and Pikhartova, 2020) that include the personalities and characteristics of individuals, such as their resilience, and how these interact with life events such managing transitions such as becoming a parent, job changes, changes to health status, retirement, and bereavement. This approach has been criticised for appearing to 'blame' individuals for being lonely, which can lead to stigma if loneliness is perceived as a personal failing (Agren and Cedersund, 2020; Oman, 2021; Malli *et al.*, 2023).

Acknowledging that wider structural and socio-cultural (macro level) factors also drive loneliness (Burholt *et al.*, 2020; Prohaska *et al.*, 2020; Victor and Pikhartova, 2020), Walsh *et al.* (2017), and Burholt *et al.* (2020) have argued that we can better understand the causes of and solutions for loneliness experienced by older people through a wider lens of social exclusion. Walsh *et al.*'s (2017) framework argues that loneliness (one manifestation of exclusion from social relations) is related to income (economic exclusion), access to services and transport (structural exclusion), how people feel about their community and neighbourhoods (community exclusion), how accepted they feel in society (socio-cultural exclusion), and how much influence they have through local and national democratic systems (civic exclusion). This article will focus on how two of these overlapping domains: socio-cultural exclusion and structural exclusion interact with loneliness.

Socio-cultural exclusion describes the societal norms and values which exclude those who are different (Walsh *et al.*, 2017). For example, ageism is discrimination against older people based on prejudiced stereotypes about their competencies. Ageism can lead to existential and social loneliness through the internalisation of negative stereotypes, such as the conflation of older age with frailty (Barke, 2017). This may then lead to their avoidance of community spaces where they either don't feel welcomed or accepted, or able to participate (Barke, 2017; Shiovitz-Ezra *et al.*, 2018). Another example of a socio-cultural attitude leading to exclusion the political and cultural ideology of individualism which emphasises self-reliance, as opposed to collectivism, which values interdependence (Baratto *et al.*, 2021). Loneliness is more common in individualistic societies, like the United Kingdom (UK), because citizens have fewer social networks, less family ties, and are expected to be responsible for themselves and not ask others for help (Baratto *et al.*, 2021).

Structural exclusion refers to having limited access to resources and services and is associated with loneliness (Burholt *et al.*, 2020; Prohaska *et al.*, 2020; Victor and Pikhartova, 2020; Myck, Waldegrave and Dahlberg, 2021). Loneliness is more prevalent where there are fewer statutory services and limited access to public transport, which result in fewer opportunities for people on lower incomes to maintain relationships and access health and care and leisure activities (Pratley, Valtorta, and Hanratty 2012; Urbaniak and Walsh, 2021). Cuts to public transport have a particularly detrimental effect on loneliness in rural areas especially amongst people who do not drive (National Assembly for Wales, 2017).

Addressing loneliness amongst older people

Most support to reduce loneliness amongst older people aims to provide opportunities for social participation through one-to-one or group interventions such as offering social activities, befriending, and peer support (O'Rourke *et al.*, 2018). Psychological interventions (Robertson, 2019; Hagan, 2020) and courses targeting tailored interventions for dealing with critical life transitions, such as retirement (Barke, 2017), have also been explored. However, very few of these interventions have been evaluated, or found to work, and consequently many statutory services, voluntary sector organisations and charities are running projects to reduce loneliness in the UK without a supportive evidence base (Fakoya *et al.*, 2020; Fried *et al.*, 2020).

Oman (2021) has problematised the prevailing policy narrative that loneliness can be resolved through increased social participation as it unhelpfully conflates social isolation with loneliness and ignores the wider causes including discrimination and poverty. Conceptualising loneliness within social exclusion changes our understanding of potential policy and practice solutions. If loneliness is linked to wider social exclusion, then a more holistic approach is needed, that

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moves the focus away from individual interventions for social connection (Walsh *et al.,* 2017; Hagan, 2020; Fried *et al.*, 2020; Malli *et al.*, 2023). This could include investment in mental and physical health, social services to improve health and well-being (Courtin and Knapp, 2017), and better public transport (National Assembly for Wales, 2017). Other ideas include developing age-friendly spaces (Dahlberg, 2020) and interventions to address negative age-related stereotypes (Shiovitz-Ezra *et al.*, 2018). Challenging stigma and negative cultural associations with loneliness may reduce self-stigma (Barke, 2017) and encourage people to access support (Goll *et al.*, 2015) and health care (Jovicic and McPherson, 2020). However, there is limited research exploring these approaches.

This article sought to understand the perspectives of what causes loneliness in one underpriveledged community for the purpose of better understanding how to address it, and coproducing community-driven solutions. The seldom-heard perspectives of residents and service providers contributes to a gap in the empirical research, which has rarely asked these communities for their input.

The study

This article presents findings from the Isolation and Loneliness Experienced by Older People (ILOP) project, which explored the drivers of loneliness in the over fifties (Naughton-Doe, Manchester and Boam, 2016; Manchester and Barke, 2020). The article explores the data collected in 2016 from a community in South Wales, which is a former mining town with high levels of deprivation, unemployment, ill-health, and high numbers of people claiming welfare benefits. In 2024, the area still contains some the most materially deprived geographical communities both in Wales and Europe. The low threshold for 'older person' reflects the gap in life expectancy (nine years) and healthy life expectancy (sixteen years) between the Welsh Valleys and the rest of the UK at the time of the research (Public Health Observatory Wales, 2011).

Research methods

Between April 2015 and August 2016, two embedded researchers were co-located between the University of Bristol, and a voluntary sector organisation funded by Communities First, the Welsh Government's fifteen-year anti-poverty programme that ran between 2002 and 2017. Embedded research improves knowledge production and dissemination through researcher and practitioner networks and experience (Cheetham *et al.*, 2018). In this case, the 'embeddedness' enabled the researchers to gain a deep understanding of the local area through working closely with the Communities First team, map services, meet community leaders, and speak with residents.

The project had three iterative methods. As Table 1 reports, the first phase of the project involved working with local community groups and commissioned artists to understand the experiences of loneliness amongst older people. The second stage recruited local older people with lived experience to develop community-based solutions through action research. This article reports the third phase, led by the author, that developed a community-wide strategy for solutions to isolation and loneliness (Naughton-Doe *et al.*, 2016).

Between February and August 2016, opportunistic and purposive strategy enabled us to reach community members who felt lonely and the professionals and practitioners that supported them. Local service leaders were invited to participate in face-to-face focus groups to explore the causes of and solutions for loneliness amongst older people. Two focus groups lasting two hours each were facilitated by two researchers following a semi-structured topic guide that included questions about what caused loneliness locally, available services and the barriers to accessing them, as well as ideas for support. Professionals who could not attend the focus groups were invited to one-to-one interviews that used an adapted topic guide.

Older people who were experiencing loneliness were recruited to semi-structured interviews by the researcher and local people from phase two of the research, who advertised and explained the research at stalls set up in the communal areas of supported housing schemes, outside a health

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Table 1. Data collection methods and participants across the project

Method	Participants	Number of participants
Two focus groups with local service providers	Representatives from services including a Voluntary action service, Care & Repair, a mobile library, Primary Care Community Coordinators, a Development Trust, MIND, Drink Wise Age Well, Age Connect, Tesco's volunteers, and befriending schemes	17
One focus group with local residents aged 50+	Attendees at a social group held at a supported housing scheme	16
Interviews with community leaders	Primary Care Community Connectors, Development Trust staff, local club leaders, and a youth club worker	8
Depth interviews with local people aged 50+	Residents in social housing schemes and attendees at social clubs	8
Attended community events and had informal conversations with attendees and local service staff	Attendees at events including a 50+ Forum, Health and Social Care Forum, Over 50's tea dance, Drink Wise Age Well event, and a Primary Care information event	Approx 40 informal conversations
Informal conversations with local people (aged 50+)	Residents at five supported housing schemes across the community	Approx 15 informal conversations
Action research to coproduce a social group to alleviate loneliness	Volunteers who were residents (aged 50+) from the local community	4

centre, and at a community event for older people. It was difficult to recruit people to interview due to the timescale and possibly the stigma of loneliness. Looking for ways to involve more participants, a supported housing manager was approached to act as a gatekeeper to recruit people attending a coffee morning. The group opted for a focus group rather than be spoken to separately. In addition to focus groups and interviews, throughout the research, informal conversations and researcher reflections were recorded in a field diary and included as data.

The data were transcribed verbatim and fieldnotes were typed up before being entered in the data analysis package, NVivo. Transcripts were analysed using Ritchie and Lewis' (2003) Thematic Analysis Framework to identify key themes in the responses that could answer the research question about the causes and solutions to loneliness. Codes and categories were developed by the author by considering each line, phrase, and paragraph of the transcripts to summarise what the participants were describing. Similar codes were developed into a coding framework, which was reviewed by the wider ILOP team to ensure rigour. The transcripts were then re-analysed using the agreed framework, and findings were organised into themes with the ILOP team in an iterative process.

Ethical approval was obtained from the University of Bristol Ethics Committee. Participants gave verbal or written informed consent. All participant's data has been anonymised, and pseudonyms are used throughout to protect confidentiality. The author and research team have written about the complex ethical challenges of researching loneliness with older people elsewhere (Manchester and Barke, 2020; Naughton-Doe *et al.*, 2022).

Findings

Many statutory and voluntary sector services and informal community groups identified that they were either directly or indirectly addressing isolation and/or loneliness amongst older people (see Table 2 for a full list). Two services – one in primary care and one in the community – mapped

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Table 2. Services in the community

Type of service	Service	Description	How they addressed isolation and/or loneliness
Formal	Community coordinator	Mapped services and provided information, advice and support to anyone over 65 for any purpose or reason	Provided information to older people about local services to reduce isolation and/or loneliness
	Social prescribing link worker in GP surgery	Building links between the voluntary sector and primary care; bringing together housing, health, and social services in a person-centred approach to older peoples services	Took referrals from GPs to connect older people to local services to reduce isolation and/or loneliness
	Drink Wise Age Well Social Clubs	An alcohol prevention service that raises awareness about the harms alcohol can cause to the over 50s; setting up social clubs to provide an alternative to drinking	Identified that a reason for drinking was loneliness, and set up social clubs as an alternative to pubs with the aim to reduce loneliness and combat drinking
	MIND five ways to well-being project 5	Wellbeing activity sessions which include physical activity, quiz, creative arts and community building sessions; coffee mornings and activites in supported housing schemes	Identified loneliness as a driver of mental health problems and set up social clubs to offer spaces to connect
	Care and Repair home repairs	Free or affordable home repairs to people over 50	Identified that many older people were isolated, and their services offered practical support
	Age Connect – advice, learning, leisure, advocacy, escort outdoors	A range of services including 'escort outdoors' that provides people with support to get outside	Supported older people participate in their communities to overcome social loneliness
	British Red Cross-Befriending	Befriending service and counselling for bereavement	Offered a befriending service and counselling to overcome emotional loneliness and isolation
Informal	Cafe	Church based café with social activities	Offered opportunities to participate in social activities
	Development Trust monthly coffee morning	Monthly coffee morning for older people	Opportunities to participate in group social activities
	Bingo Club	Women over 50 play bingo and go on trips and activities	Opportunities to participate in group social activities
	Walking club	Walks for any age, mostly over 50s	Opportunities to participate in group social activities
Local Authority	Daycentres	Local Authority managed care	Provides respite for carers and opportunities to participate in group social activities for older people who use the services
	50+ Forum	Quarterly meetings to discuss policy and organisations with older people	Provides staff time to consider the needs of older people, including loneliness
	Older People's worker	There is a staff member at the council responsible for older people policy	Provides staff time to consider the needs of older people, including loneliness
	Leisure Trust – free space and support	Not-for-profit organisation that delivers some aspects of Local Authority	Offers space for community groups to hold activities in

(*Continued*)

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Table 2. (*Continued*)

Type of service	Service	Description	How they addressed isolation and/or loneliness
		Services for subsidy for the Local Authority; organisation is providing building space and support to people over 50 wanting to set up activities or events in their communities	
	Library visiting service	Home Links, a visiting library service for people over 50	A service to overcome isolation and help older people to read

local support and provided information about available support and activities to older people who may be isolated and/or lonely. Two voluntary sector organisations promoting mental health set up social groups for older people and a separate service provided counselling and befriending. Others aimed to reduce isolation by helping older people to get outside, or by bringing services into their homes, such as a visiting library or repair service. There were also four social clubs that were run by locals, including a bingo club, a walking club, and two coffee mornings.

Two focus groups were attended by seventeen practitioners from a wide range of these services including those working in the statutory, informal, and formal voluntary sector (see Table 1). Three professionals were also interviewed one-to-one, including senior management from the Community Development Organisation where the research was embedded, and two primary care link workers. Five older people who identified as lonely participated in interviews, including four men (aged between sixty and eighty-five) who lived in supported housing and one disabled woman who lived in the community (aged sixty to seventy). Demographic information was not collected from the fourteen participants in the focus group at the supported housing coffee morning due to it being spontaneous; however, they were all white females aged sixty plus.

Participants in the practitioner focus groups identified that despite some support being available, including information services and group activities, loneliness was still an issue for the older residents they supported. This section will now present their reflections on the causes of loneliness summarised into four themes; limited availability of services; mobility and transport; ageism; and stigma.

Limited availability of services

When asked about what caused loneliness, service providers, health professionals, and older people commonly reported that local service provision was inadequate. There was a perception that reduced funding for statutory and voluntary sector services had adversely impacted availability, which affected social care, access to doctors such as General Practitioners(GPs), informal community-led provision, and housing. Professionals perceived that most statutory day centre facilities where frailer older people could meet, or provide respite to give carers opportunities for socialising, had either been closed, or long waiting times prevented access. A social housing manager explained:

> The other day [we rang a] day centre, because my friend's mother had dementia, and . . . you had a list . . . You had to wait for a space to become available.

Voluntary sector services also had waiting lists. For example, a popular befriending scheme that relied on volunteers could not keep up with demand. The manager explained that staff perceived waiting for support could intensify older people's loneliness and worsen their mental health:

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> I've usually got about six people on a waiting list with each befriending project. It just has such a negative impact on their health and wellbeing.

Similarly, when considering access to psychological therapy, a community link worker reflected on the difficult process of asking the GP for support with mental health:

> If you are referred for any mental health issues, because loneliness is a mental health issue, right – no chance. You're talking possibly eighteen months to two years. God, it takes you a year to see a cardiologist with your heart.

The fear of the waiting list also created barriers for people, preventing them from accessing support, as a service provider explained in a focus group:

> I wonder if that is one of the motivating factors behind people saying, 'No, I'm not lonely,' or not, perhaps, identifying that need in themselves, because, if you are aware, even if you do admit, 'Yes, this is a problem for me, I'm still not going to be able to access the services,' or, I'm going to be on a waiting list,' or, 'I'm not going to be able to get to somewhere, even if I do admit it'.

Residents in the supported housing focus group and the manager of the scheme noted that the numbers of wardens in supported housing had been reduced during a transfer from the council to the private sector. Where wardens had once organised social activities, their roles now centred on administration, which reduced the opportunities for social interactions between residents. An excerpt from the fieldnotes explains:

> [The warden] told me she was supposed to sit in the office now, during the group activities, and not participate. She felt this was totally inappropriate and took away from the fact her job was about interaction and building relationships.

Although there were many voluntary sector services, professionals reported that funding for these organisations had been reduced or cut. This was confirmed by residents in the supported housing focus group who explained that a cooking group, a Zumba group, supported housing social activities, and the local bowls club had all recently closed. It was perceived that services were not being cut due to lack of interest or need, but due to a shortage of funding. The Communities First manager explained '*at the end of the day, it's always connected to money*'. Similarly, the supported housing manager explained that services were shutting down because:

> There's not even enough money to keep them going. It's all down to money, the same with the GPs, and everything else. It's all down to money.

At the time of the research in 2016, an announcement that funding for the Communities First anti-poverty programme in Wales was ending in 2017 caused concern this would worsen the problem.

Mobility and transport

Participants identified limited mobility and poor transport as key contributors to loneliness in their town. The town has a higher-than-average proportion of disability allowance claimants and a lower life expectancy compared to the UK. Mobility issues affect a high proportion of older residents, and the topography of the town always makes it more challenging to walk, as it is hilly and spread across a valley. The inability to travel places including local amenities, shops, and

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health and care services reduced personal agency. Further, people found it hard to meet friends and family. Summarising these issues, a service provider in the focus group explained:

> I think the difference with older people is, quite often with younger people they are able to access transport and to be able to get out and things, whereas, perhaps, with older people, because of health problems and mobility problems, and because of the nature of the valleys, the topography [they cannot get out as easily].

Local transport was also perceived as inadequate, with participants reporting that the local bus services had been reduced, which further exacerbated mobility issues. In some cases, regular buses had been replaced with services where people had to arrange in advance to for a bus to call at their stop:

> There is no [regular] bus service at all. You have to book a service a day ahead. [Participant in service provider focus group]

This created an additional task to complete before going out and removed a spontaneity.

Car access was also an issue. Service providers and interview participants explained that very few older women in their community had learnt to drive, made evident by only one out of six women in the action research project having a licence. Many women were bereaved, and their spouse had been the only driver, which was also the situation of a participant in the interviews. Sheila (aged sixty to seventy) explained her frustration at being told to go to groups by her mental health team, but not having transport:

> Again, I'm saying to people, and I don't seem to be getting through, I'll go anywhere, but how do I get from A to B? It's alright saying, 'Yes, you can go here and you can go to this centre and you can go up here, we do this, we do arts and crafts and all that.' Yeah, great, I'd love to go, but how do I get from this house without myself paying for a taxi, and, when you're on a limited income, forty pounds-a-month coming out of your money is a heck of a lot of money.

Compounding this, there were few local shops, and most post offices and other services were located only in the centre of town, meaning those on the outskirts could not access them without cars or using the inadequate public transport.

Ageism

Older residents and service providers both raised age-related discrimination as a cause of loneliness in their community. Participants in the focus groups explained that older people felt excluded because they were sometimes spoken to differently as a direct result of their age. A conversation in the service providers focus group, which included some professionals who identified as older people such as Mary, highlighted that assumptions were often made about older adults' sensory and cognitive function:

> Maureen: [Older people] are not going to bite you, they are not going to hit you, they are not scary people.
>
> Sarah: Yes, because I think some people are genuinely afraid of older people.
>
> Mary: Yes, they don't know where we come from or what we do.
>
> Kelly: They don't know how to speak to people.

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Sarah: No, they think they are hard of hearing.

Kelly: Yes, they must be deaf or batty, so we will treat them like a fool.

Sarah: And treat them all the same, regardless.

Mary: Talk in a very loud voice and very slowly.

Participants perceived that this discrimination contributed to loneliness because older people were being treated differently by other age groups, including by shop workers and professionals. For example, older people who took part in interviews perceived that they were ignored or avoided by other people:

> Old age is a lonelier time as the body starts to fail you. Some people avoid you. Some people do not like to chat to you anymore. [Graham, aged eighty to ninety]
>
> People just forget you when you get old. They just don't think you count, which is awful. [Barry, aged seventy to eighty]

This exclusion was also felt by women who took part in the focus group in the supported housing coffee morning. They felt that their age had resulted in them being treated differently by their GP. For example, when talking about an initiative to encourage GPs to refer older people to social prescribers, the women discussed:

Rita: But, when you say that GPs are going to be involved in it, that's a laugh, that is, because you can't get an appointment to see a GP.

Lorraine: Because they just don't care. They don't . . . do they? I'm not being facetious.

Rita: No, they don't.

Coral: They don't care.

Lorraine: Once you reach sixty, that's it.

Tina: You can shoot yourself, as far as they're concerned.

Interviewer: Is that something that everyone agrees with?

[Nodding]

Several: Yes.

When ageism was explored with service providers, they blamed negative associations with older people on the media:

> When do we see anything other than older people, the fact that everyone's living longer is crippling social services, or the fact that they've had to increase retirement age because older people are crippling the pension system? When do we ever see anything about how much have they contributed? [Participant in service provider focus group]

Here we see how a prevailing culture of ageism could result in existential loneliness, as older people are regarded as no longer contributing to society.

Older people were also experiencing indirect ageism as services designed for them were often based on ageist stereotypes. Many of the activities organised to combat loneliness were based on assumptions of what older people may like, without asking them. These included tea dances, bingo groups, or 'knit and natter' groups, and socialising with other older people. Following attending a tea dance and talking to some attendees, the researcher reflected:

> Several older people noted this activity was the stereotype of what people thought older people wanted, but in reality, they craved some variety. My gut reaction was it was very

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> stereotypical. There was bingo, quizzes, primary school children singing, and tea and cake. [Researcher field diary]

Whilst some older people enjoyed these activities, older people are not a homogenous group and many practitioners felt that activities should be more diverse and coproduced to meet different needs. This perception that older people wanted these activities, without asking them first, is an example of ageism that can lead to social loneliness if older people do not attend activities and/or existential loneliness if they feel patronised.

Stigma

The stigma of loneliness was raised as a contributing factor to explain why people remained lonely despite some help being available. A prevailing socio-cultural attitude that loneliness is a problem brought on by an individual's personal shortcomings was evident throughout the research. When participants in the social housing focus group were asked why people might feel lonely, they replied:

> Kate: Because they won't get off their backsides and do anything, because it's a spiral, isn't it? The more depressed you get, the less you want to do, and it's like, because it is an effort.
>
> Tina: Well, not us, because, obviously, we are here today, because we do get off our backsides and do things.

When asked what might help people feel less lonely, participants often replied with variants of 'It's up to them. They've got to do it themselves' [participant in service provider focus group]. As is evident from the findings presented so far, many respondents did also identify other wider factors contributing to loneliness, but the rhetoric that people had control over feeling lonely was a commonly held belief. When this was explored in interviews and focus groups with professionals, participants related this to a culture of pride and self-reliance:

> These people are proud and strong, they come from the miner's tradition. A shut up and get on with it mentality. Don't talk about your feelings, especially the men. [Participant in focus group]

This contributed to a culture where people valued being independent and not asking others for help. For example, a respondent in the professionals focus group who had lived experience of feeling lonely as a bereaved older person explained:

> Maureen: I am resilient because I have learnt I have to be resilient. If I don't do things for me, nobody is going to do them for me . . . I mean, lots of things have happened in my life, I don't go round with a barrier on my head. I have overcome them, because I have got to, because otherwise I would have locked myself in the house and have been there.

Whilst no one overtly criticised people who are lonely, attitudes that indirectly blame an individual for feeling lonely partly explains the stigmatising nature of loneliness. If being lonely is something that is a personal responsibility to manage, then feeling lonely is a personal failing, and helps to explain why people may not want to ask for or access support.

Discussion and conclusion

The research explored perceptions of drivers of loneliness amongst older residents in an underprivileged community in South Wales through a qualitative study exploring the seldom

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heard perspectives of service providers and isolated older residents. Participants in focus groups, interviews, and informal conversations identified many causes of loneliness that went beyond isolation, an individual's personality or life circumstances. Instead, the findings support the more complex view of Walsh *et al.* (2017) that loneliness cannot be viewed separately to social exclusion, including structural and socio-cultural exclusion, which will now be explored.

Structural exclusion and loneliness

Participants in the research identified examples of structural exclusion (Walsh *et al.*, 2017) as key drivers of loneliness in their materially deprived community, including a reduction of statutory services and inadequate access to transport. These findings support Courtin and Knapp (2017) who argued that access to transport, health, community, and social services are essential if we are to avoid isolation and loneliness. The empirical qualitative data in this study helps to explain quantitative data that has identified that loneliness is more prevalent in deprived areas (Prattley *et al.*, 2020; Victor and Pikhartova, 2020; Urbaniak and Walsh, 2021). For example, older people on lower incomes who are less mobile, cannot access a car, and cannot afford taxis, face barriers to accessing services, or visiting family and friends. Although there were some services that aimed directly or indirectly to reduce loneliness, locals perceived there were few opportunities, and that older people could not easily access them either through waiting lists or mobility challenges.

The austerity policies of the Conservative and Coalition governments since 2010 may explain the perception that there are less services available because their cuts have directly led to a reduction of public services (Irving, 2021). Whilst the fieldwork was conducted in 2016, the findings are still relevant today and furthermore, the issues facing communities across the UK have worsened. For example, many communities in South Wales, including the community in this research, lost vital regeneration funding when the UK left the European Union (Hunt *et al.,* 2016). Despite recognition that good transport is essential for tackling loneliness in Welsh Valleys, services have been further reduced (Williams *et al.,* 2021; Age Cymru, 2023). Austerity policies have continued, which meant the UK's public sector is weakened and was less able to respond to the challenges of the Covid-19 pandemic (McKee *et al.,* 2023). Social distancing policies during the pandemic also increased loneliness, meaning there was more demand on these services, particularly for older people who were asked to shield (Wong *et al.,* 2020; Naughton-Doe *et al.*, 2023). The cost-of-living crisis and heating bills have reduced the incomes of many, further reducing their capacity to pay for social activities (Hill and Webber, 2022).

Whilst loneliness has been higher on the political agenda through subsequent loneliness strategies and reports (HM Government 2018; 2021), this has not yet led to an understanding that drivers of loneliness include austerity and continued lack of investment in infrastructure in communities. Transport is mentioned as a priority in these strategies, and yet investment in local services has not materialised. The data presented in this article suggests that to address loneliness, more attention should be paid to structural exclusion to provide more support and better ways to access it.

Socio-cultural exclusion and loneliness

The findings show that socio-cultural exclusion is a main driver of loneliness through prevailing attitudes, including ageism and a culture that values self-reliance and individual responsibility. The experiences of exclusion felt by participants in this study supports Shiovitz-Ezra *et al.*'s 2018, 2023 conclusion that ageism can lead to loneliness if people stop talking to older people, and/or make negative assumptions about them, undermining the possibility of meaningful interaction. In addition to this social loneliness, older people's experiences also aligned with existential loneliness as they felt separate and undervalued. The ageist failure to understand older people as a diverse group of people also contributed to loneliness.

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Since the research was conducted, there has been increased exposure to ageist narratives that may have worsened existential loneliness (Shiovitz-Ezra *et al.,* 2018). For example, the UK Government's Covid-19 pandemic social distancing policies during 2020–2021 may have contributed to ageism. During the pandemic, anyone over fifty, regardless of individual circumstance, was categorised as clinically vulnerable and advised to shield (Brooke and Jackson, 2020; Jeong *et al.,* 2020). This is a perception that those campaigning against ageism had previously worked hard to challenge (Naughton-Doe *et al.*, 2023). Echoing the concerns of participants who suggested GPs did not prioritise people over sixty, the rationing of health services in favour of younger people was frequently discussed during the pandemic (Rockwood, 2021). The 2023 Covid-19 Enquiry found that the UK Prime Minister believed older people should 'accept their fate' (BBC News, 2023). Consequently, the pandemic may have further exacerbated loneliness through contributing to contributing to ageist narratives.

This research supports arguments by Kitzmüller *et al.* (2018) that loneliness is driven by prevailing socio-cultural norms of individualism. People over fifty who participated in interviews and focus groups were often heard to blame individuals for their feelings. Many felt that the older person was responsible for tackling their loneliness, and this was mirrored in policy and practice through approaches that offered opportunities to participate in social groups or befriending, rather than exploring structural and/or socio-cultural determinants. This is perhaps an impact of the individual responsibility narrative that has dominated since Thatcher and the New Labour 'Third Way', that has encouraged citizens to take greater control over themselves, their families, and communities, without acknowledging the role of wider structural disadvantages (Levitas, 2005). Agren and Cedersund (2020) have noted a similar process in Sweden, whereby older citizens were encouraged to be autonomous and independent in juxtaposition with the ideological withdrawal of the welfare state. This shift has created a narrative of individual responsibility which contributes to the fallacy that individuals are to blame for their disadvantages. Feeling lonely, like being mentally ill, is associated with personal failure which results in stigma that prevents people being able to speak up and ask for support (Goll *et al.*, 2015).

Implications for policy and practice

The WHO Commission for Social Connection (2024–2026) recognises the importance of addressing loneliness owing to its detrimental impact on health and well-being. An announcement in 2024 of closure for the Campaign to End Loneliness, which is partially funded by the UK Government, may be a signal that addressing loneliness will be deprioritised. In this climate, the importance of preventing and reducing loneliness must be emphasised, and this should be with a focus on socio-cultural and structural drivers in addition to individual support.

Funding programmes to create social opportunities are often simpler and cheaper than addressing complex structural determinants. As Oman (2021) argued, we cannot address loneliness solely through encouraging participation in society without also considering its wider causes. We need greater investment in health, social care, and community services, and an awareness of the structural drivers. Comprehensive, free, and non-stigmatised public transport can also help alleviate loneliness (Green *et al.,* 2014).

Ageism as a form of socio-cultural exclusion exacerbates loneliness and can be addressed through challenging age-related stereotypes and service-coproduction with older people (Shiovitz-Ezra *et al.,* 2018; Naughton-Doe *et al.*, 2023). Initiatives to challenge ageism could include age-positive campaigns and support to overcome internalised ageism (Naughton-Doe *et al.*, 2023).

Limitations

This paper is the perspective of one, white, female researcher, and the participants in the research were also white and predominantly female. Consequently, the author acknowledges that

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important perspectives may have been missed, including from further marginalised older residents in the community, such as those too isolated to participate in research. Loneliness can be compounded by intersectional inequalities (Taylor *et al.*, 2021) and future research should include diverse perspectives. Further, the fieldwork was conducted in 2016, and the context has changed. More research is needed to explore the impact of Covid-19, Brexit, and the cost-of-living crisis and related social exclusion on the loneliness experienced by older people in deprived communities. Further research could also untangle the impact of ageism on loneliness and particularly existential loneliness, which has been less researched.

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