The ‘loneliness pandemic’: implications for gerontological nursing

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Carlos Laranjeira

ABSTRACT

The COVID-19 pandemic compelled states to limit free movement, in order to protect at-risk and more vulnerable groups, particularly older adults. Due to old age or debilitating chronic diseases, this group is also more vulnerable to loneliness (perceived discrepancy between actual and desired social relationships) and social isolation (feeling that one does not belong to society). This forced isolation has negative consequences for the health of older people, particularly their mental health. This is an especially challenging time for gerontological nursing, but it is also an opportunity for professionals to combat age stereotypes reinforced with COVID-19, to urge the measurement of loneliness and social isolation, and to rethink how to further adjust interventions in times of crisis, such as considering technology-mediated interventions in these uncertain times.

Key words: Older people ■ Quality of life ■ COVID-19 ■ Holistic care

Social isolation and loneliness are two of the major emergencies our societies face in the 21st century (Prohaska et al, 2020). Although both emergencies are not a direct consequence of COVID-19, the pandemic has aggravated them and increased our awareness of these issues (Hwang et al, 2020). The COVID-19 pandemic has forced different countries to limit free movement, in order to protect at-risk or more vulnerable groups, particularly older adults living in residential care homes or in the community. Due to old age or debilitating chronic diseases, this group is more vulnerable to loneliness and social isolation when their usual ways of connecting with the family or with the entities providing social care and healthcare services are unavailable or limited (Berg-Weger and Morley, 2020; Prohaska et al, 2020).

Loneliness and social isolation are two distinct concepts and can be experienced individually or jointly. Loneliness is commonly defined as a subjective negative feeling associated with a perceived lack of a wider social network (social loneliness) or the absence of a specific desired companion (emotional loneliness). The definition of social isolation is less consensual. Many studies consider social isolation a unidimensional concept, defined as the objective lack or paucity of social contacts and interactions (Fakoya et al, 2020). Alternatively, multidimensional definitions have incorporated the quality, as well as the quantity, of relationships—with loneliness falling under the subjective component of social isolation (Maltby et al, 2020).

Before the outbreak of COVID-19, nearly one-third of older adults in Finland experienced loneliness and/or social isolation and a subset (5%) reported feeling lonely 'often' or 'always' (Jansson et al, 2018). Isolation and loneliness have been identified as independent risk factors for several negative physical and mental health outcomes, such as depression, cardiovascular diseases, and poor quality of life and wellbeing. However, causal links and mechanisms are difficult to demonstrate, and further investigation is required (Courtin and Knapp, 2017). With the COVID-19 pandemic, older adults with chronic conditions were advised to stay at home, which increased their social isolation and led to depressive and anxiety symptoms (Wong et al, 2020).

To address this pandemic's most harmful effects, the World Health Organization (WHO) issued a set of preventive mental health recommendations (WHO, 2020) aimed at the general population, at families facing confinement, at professionals dealing directly with the pandemic and in a privileged position to address its immediate consequences, and at specific groups in greater isolation or vulnerability. The crisis requires large-scale changes of behaviour, therefore it is necessary, in this context, to reflect on the consequences of loneliness and social isolation for elderly people and on the action of professionals working in the field of gerontological nursing.

This article discusses the health consequences of this forced isolation on older people, particularly in terms of mental health. Understanding these effects will be important in order to design intervention strategies that mitigate the threats caused by the pandemic in terms of the social connections and socio-emotional relationships of older people.

'Social distancing' and social isolation

All human beings develop an intrinsic need to remain connected with others, therefore social distancing—ie, efforts to maintain physical distance between people and reduce in-person contact to reduce the spread of COVID-19—is felt as something deeply unnatural. Given the need to take refuge at home, often reiterated during the pandemic, many elderly people have remained alone most of the time and can no longer use

Carlos Laranjeira, Adjunct Professor, School of Health Sciences, Polytechnic of Leiria; Researcher, RECI (Research in Education and Community Intervention), Piaget Institute; Center for Innovative Care and Health Technology (ciTechCare), Polytechnic of Leiria, Portugal, carlos.laranjeira@ipleiria.pt

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familiar ways to connect with their primary support networks and the entities providing health and social care services. In this new normal, many of the traditional strategies for involving elderly people have become obsolete. Among the suspended opportunities for social engagement are dining venues, social and exercise activities, personal interactions related to health or recreational activities, voluntary work and employment commitments (Berg-Weger and Morley, 2020).

Governmental guidelines to remain at home and avoid contact with family and friends, and the possibility of home-delivery of medication and other purchases, have contributed to an unprecedented level of personal isolation. Although necessary to reduce transmission and spread of the virus, this isolation has a disproportionate effect on elderly people, whose only or main contacts are located outside the home, and demands urgent actions to mitigate its harmful effects (Armitage and Nellums, 2020). Such mitigation strategies must consider the psychological and psychiatric morbidity associated with the effects of the pandemic. Recent evidence on the experience of social isolation and loneliness shows that the structure and role of the social network are strongly intertwined with symptoms of anxiety and depression in the elderly population in general (Santini et al, 2020), especially for those who live alone or are widowed (Jeon et al, 2017). Conversely, social connections with a partner, family or other collective contexts increase the chances of survival in difficult situations or hostile environments and lead to a rewarding perception of time compared to time spent alone (Bavel et al, 2020).

How should we assess loneliness and social isolation?

The COVID-19 pandemic has highlighted that gerontological nurses need to dedicate special attention to the diagnosis of situations of loneliness and social isolation. This practice, if improved, may lead to the development and adaptation of evidence-based interventions in the treatment of these phenomena (Berg-Weger and Morley, 2020).

In the present context, when most people have experienced loneliness and social isolation, it should be clearly understood that these phenomena should not be perpetuated in a post-pandemic world, especially in older groups (Berg-Weger and Morley, 2020). Understanding the risk factors for loneliness and social isolation among the elderly—eg, living in a rural context, old age, living alone or in residential care/sheltered housing, widowhood, low level of education and income, poor health, low functional level, poor vision and hearing loss, and lack of friends—will foster the development of interventions to mitigate losses resulting from changes in social life, natural events or even difficulties caused by the ageing process itself. Many screening tools exist to assess social isolation and loneliness (Veazie et al, 2019) (*Box 1*). In addition to these instruments, widely used in gerontological nursing practice, it is also important to analyse the virtual social networks developed during confinement, whose maintenance is essential in times of uncertainty. The key people in the contact network should be identified (eg, confidants, links to the community in times of greater confinement, neighbours), together with a careful assessment of contact frequency, a characterisation of the type, structure, and extent of contacts, and an evaluation of the degree of satisfaction with the social reality. This will help identify how to expand that reality, for instance using technological resources recently accessed or mastered.

Box 1. Screening tools to measure social isolation and loneliness

- Lubben Social Network Scale (LSNS-6item), to assess the level of support perceived and received by family, friends and neighbours (https://tinyurl.com/sbc3upav)
- Social Disconnectedness, 8-item scale, to assess social network size and social activity (Cornwell and Waite, 2009)
- Duke Social Support Index (DSSI-10 item), a multidimensional scale measuring social networks, social interactions, and perceived and instrumental social support
- UCLA Loneliness Scale, which assesses perceived loneliness
- Social Resources Scale, part of a broader questionnaire, the Multidimensional Functional Assessment of the Elderly (Duke OARS-Older Americans Resources and Services). This social resources subscale evaluates the extent and quality of social networks and allows the classification of the elderly's social resources from 'totally unsatisfactory' to 'very good' (Fillenbaum, 2016)

Source: Veazie et al, 2019

The COVID-19 pandemic has forced people worldwide to change how they live, and has also provided professionals with opportunities to assess responses in times of crisis, identify lessons learnt, and improve intervention strategies in various fields, namely how elders can best face loneliness and isolation.

How should we intervene?

Professionals who work with the populations most vulnerable to COVID-19 must use creativity to maintain a relationship with their elderly clients and families, and to help them sustain social connections in order to relieve their loneliness, social isolation and anxiety. Social activities or public health initiatives can reduce perceived isolation, and facilitate integration in social networks and participation in community activities (Santini, et al, 2020). The use of technology by older people may increase their knowledge, strengthen family ties and increase their general connection with society. In fact, social interactions are increasingly dependent on the use of technology, benefiting wellbeing and emotional maturity, mainly by increasing the sense of connection with other people and with society in general (Haslam, 2020; Moore and Hancock, 2020).

Technology-mediated interventions are most successful when older people receive assistance. Access to the internet, but above all proper training in its use, seems to foster wellbeing and personal connections among the vulnerable elderly, promoting significant cognitive improvements over time (Morton et al, 2018). Interventions to promote social connections can be particularly beneficial for individuals with low levels of education, therefore disparities in access to technology, but especially digital literacy, must be considered (Shankar et al, 2013; Wu, 2020). In other words, special attention and increased help should be given to people less familiar with digital technologies, so they find them more user-friendly and can take full advantage of digital connections. Another major challenge is to make virtual interactions more meaningful and engaging for elderly people who experience social isolation.

It seems that interventions can be more successful when older adults are questioned interactively about their interests, preferences and needs, whether by videoconference to build interactive virtual learning programs, or through live webcasts and videos to reinforce lifelong learning opportunities (Botner, 2018). An adequate strategy to generate empathy and connection may involve a didactic and synchronic use of technologies close to people's interests. Conversely, a passive use of social networks does not contribute to the sense of belonging and social connection sought by professional interventions. The passive use of Facebook may even lead to declines in affective wellbeing. For this reason, working with older adults to help them maintain group-based connections is important and finding the best strategy to do so during the pandemic needs to be a priority (Haslam, 2020).

To strengthen people's health during a pandemic, it is necessary to think of strategies and interventions that include social (eg, social assistance and family support), psychological (eg, monitoring through online psychotherapy or psychiatry) and physical dimensions (medical teleconsultation), and that guarantee the prescription of medication for patients who need continuity of treatment. Likewise, the management of a mental illness (eg, mood disorders, mental, and behavioural disorders) can be facilitated through psychoeducation using cognitive behavioural therapy (CBT). Even when performed online, a treatment protocol with CBT components can reduce feelings of loneliness, depression, general anxiety and worry; improve quality of life; and provide better control of psychiatric and psychosocial problems (Käll et al, 2020). Additional approaches include manualised therapies (ie conducted according to step-by-step guidance), such as promoting physical activity and greater connectedness, compassion training, and engaging in spirituality. These approaches have also been shown to enhance coping, promote resilience, and reduce loneliness (Freedman and Nicolle, 2020; Lee et al, 2020).

However, social connections should not be restricted to the use of technology, especially when people do not have the resources, the capacity or the confidence to use it, making the whole process of combating social isolation even more challenging. Unfortunately, older adults, due to their lesser digital skills and potentially flawed information on the source of online social content, may be especially susceptible to misinformation and fraud (Moore and Hancock, 2020). Despite this challenge, we cannot ignore that this crisis was unforeseen and developed rapidly, which did not allow time for the elderly, professionals and families to prepare and overcome limits with the necessary speed. More accessible, low- and no-technology strategies that guarantee links between elderly people and their support networks must be considered. These could simply involve more frequent telephone contact with important people, close family and friends, voluntary organisations, health professionals or community outreach projects that can provide support during this imposed isolation (Armitage and Nellums, 2020).

In short, the daily practice of professionals now implies the use of telephone calls and video conferencing for virtual activities and personal contacts, to provide home services, to conduct visits to health services, to carry out educational work on health prevention and provide news updates (Berg-Weger and Morley, 2020). In residential care, because family visits are suspended, professionals dedicate a large part of their time providing daily updates about residents and have had to: develop new formats for family visits, including using tools such as FaceTime, WhatsApp, Skype or Zoom; organise individual activities in the rooms or group activities with appropriate physical distance; and ensure compassionate visits to people at the end of their lives (Berg-Weger and Morley, 2020).

Given the issues of frailty and loss of mobility, the problems with transport and the declining tendency to move to new areas as we age, older people's lives are more affected by their local environment than some other age groups. Initiatives to combat loneliness will be most effective if integrated into an overarching strategy to promote the wellbeing of older people; a strategy involving local authorities and agencies, that explicitly recognises the issues of loneliness and social isolation, and outlines clear actions to address them (Age UK and Campaign to End Loneliness, 2015), including:

- Raising awareness about loneliness and isolation, both among professionals and older people themselves, reducing the stigma of speaking up about what can seem a deeply personal issue and ensuring that local services understand their role in combating loneliness
- Promoting volunteering and neighbourhood networks and social activities (including community choirs, coffee mornings and faith groups) that strengthen a community and harness its capacity to tackle loneliness
- Fostering age-friendly communities and encouraging intergenerational contact.

From the perspective of health emergency management, the economics of ageing has several implications. On one hand, older people who retain their livelihood and remain self-sufficient are better equipped to maintain their health and contribute to the wellbeing of their households and families. On the other hand, poverty increases strains on health, heightens susceptibility to illness, and reduces older people's capacity to cope with hardships imposed by a crisis. Finally, as older people experience increasing destitution, this can further reduce their ability to afford and access health care, increasing morbidity and disability (Hutton, 2008).

Necessary assistance must continue to be provided so that the physical and mental state of those most at risk of isolation and loneliness does not worsen as this pandemic continues. In the post-pandemic world, we can use these crisis intervention strategies to develop our preparedness moving forward.

Conclusion

Due to the imposed physical distancing to protect public health, the pandemic poses unequivocal challenges to the preservation of physical and mental health, especially when considering elderly people who live alone. However, gerontological nurses should not view this crisis only through the lens of the threat of its consequences, or their irreversibility. On the contrary, the crisis should be taken as an additional opportunity for professionals to learn about this experience, increase care planning, and intervene in the face of the consequences of social isolation, developing and testing interventions adjusted to the 'new normal'.

While the world seeks to obtain more knowledge to respond to this pandemic, gerontological nurses can continue to combat the logic of ageism, continually recalling the heterogeneity of the older population and their multiple contributions in different spheres. These nurses can develop their technological skills and expand their use of technology, as a viable option for health service provision, together with traditional interventions; they can learn more about crisis and post-crisis interventions, the stressors resulting from a crisis, and the increased needs experienced by the elderly and family members (depression, anxiety, financial challenges etc) and they can develop new approaches and practices to face evidence-based loneliness and social isolation.

Hopefully, this commentary will inspire new research in this emerging area. Knowledge in this field may help avoid feelings of social isolation and loneliness among older adults dealing with the circumstances of the COVID-19 crisis and help them transition into the post-COVID-19 world. **BJN**

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KEY POINTS

- The COVID-19 pandemic poses unequivocal challenges to the preservation of physical and mental health, especially when considering elderly people who live alone
- Nurses can develop new approaches and practices to address evidence-based loneliness and social isolation
- Initiatives to combat loneliness will be most effective if integrated into an overarching strategy to promote the wellbeing of older people
- An adequate strategy to generate empathy and connection may involve the didactic and synchronic use of technologies close to people's interests

CPD reflective questions

- How can we apply what we currently know about loneliness and social isolation to determine the best holistic care for older people?
- Do we know enough about the importance of social connections, especially for those who are sick or vulnerable?
- How is the coronavirus pandemic impacting the mental health of older people in your clinical area?