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Editorial

Addressing Loneliness in Older Adults During the COVID-19 Pandemic

A Commentary on "Understanding Psychological Distress and Protective Factors Among Older Adults During the COVID-19 Pandemic"

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The importance of loneliness and social isolation for health has become increasingly salient since the start of the COVID-19 pandemic and need for physical distancing to prevent spread of the virus.[1] While the impacts of loneliness and social isolation on health, well-being, and longevity are well documented,[2] the importance of social connection for health is often under-appreciated by clinicians and patients alike. However, this may be changing as public discourse increasingly focuses on how restricted social opportunities can lead to depression, anxiety, and suicidal thoughts in some individuals. Often missing from this dialogue, however, is that social isolation—a lack of interactions and/or connections with other people—does not equate to loneliness—a subjective feeling of distress about a lack of interactions and connections. For some, time alone equates to solitude and may even be welcomed. For others, infrequent interactions with others may be deeply distressing and lead to feelings of not belonging and thoughts of suicide.

In this issue, Sams et al.[3] explore contributors to depressive symptoms, anxiety symptoms, health anxiety, and loneliness for community-dwelling older adults in the context of the COVID-19 pandemic. They present results from a cross-sectional descriptive study with 501 adults age 60 and older recruited via Amazon Mechanical Turk (mTurk) and Prolific

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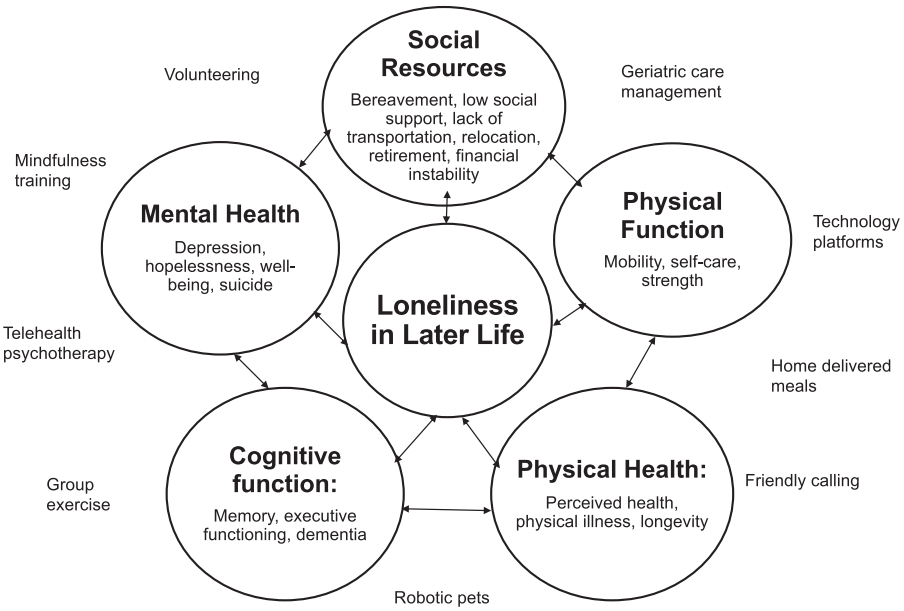
Research Platforms in June 2020. The study was designed to examine factors that may increase the likelihood of psychological distress and loneliness after several months of physical distancing measures during the COVID pandemic. The premise underlying the design of this study is important: the presence of stressors does not necessarily equate to distress, especially when individuals are psychologically equipped with coping mechanisms and ways of making sense of their experiences that produce resilience. Results of this study indicated that in June 2020, the majority of older adults surveyed did not report clinically significant levels of psychological distress or loneliness, consistent with other reports indicating that the greatest mental health and social impacts of the pandemic appear to be among younger adults.[4,5] As one example, a nationally representative study of younger adults (ages 18−25) during April 2020 found that 43% of the sample reported clinically significant loneliness on the UCLA Loneliness Scale. While direct comparisons should be made with caution given sampling and measurement differences, Sams et al. found that only 26.5% of their sample of older adults reported clinically significant levels of loneliness. While numerous reasons likely account for the relatively lower levels of loneliness in the older adult sample, aging-associated strengths such as emotion regulation, wisdom, and resilience likely play a role. Indeed, Sams et al. found that individual scores on a measure of psychological resiliency predicted likelihood of psychological distress and loneliness over and above financial instability and physical health.

The study by Sams et al. also highlighted the strong linkage between psychological distress and loneliness as well as factors associated with both distress and loneliness—financial instability, worse physical health, and less resiliency. Results also suggest that self-reports of engaging in social activities—social events or group activities at home or in the community—may not reliably differentiate those at risk for loneliness. Interestingly, results from this study indicated that 'not getting physical exercise' was more common for those older adults who reported psychological distress and loneliness, suggesting an alternative target for intervention rather than providing social events or groups to alleviate loneliness.

There are numerous pathways to loneliness in later life, even in the midst of the shared experience of the pandemic. Figure 1 depicts key correlates of

FIGURE 1. Towards a personalized approach to selecting programs for loneliness in later life.



loneliness in later life that may function as both causes and consequences of loneliness. Absent from the model (for clarity of presentation) are societal level factors that may increase vulnerability to loneliness including systemic racism, ageism, and structural inequalities in access to healthcare and other resources. This model may be useful for clinicians working with older patients in selecting personalized interventions to reduce loneliness and for researchers and program managers in selecting programs to develop or test for a group of older adults. The model includes interventions that have shown efficacy (or a signal for efficacy) in either reducing loneliness in older adults or reducing psychological distress among lonely older adults that can be provided safely in the context of physical distancing measures (with modifications in some instances). Despite the public health significance of social isolation and loneliness, there are few evidence-based strategies to improve social connections[2] and even fewer that are feasible to implement while following physical distancing guidance[6] so these programs can be considered promising approaches rather than evidence-based. As one example, an older person with several chronic conditions and functional impairment who cannot leave the home might benefit from a friendly calling program during the pandemic when friends and family cannot visit; one such program was tested in a randomized trial with older adults during the pandemic and shown to reduce loneliness and improve mental health.[7] An older person experiencing loneliness and depression who is able to leave the home for an outdoor program during the pandemic might benefit from a group exercise program, such as Tai Chi or a culturally-tailored program such as ¡HOLA, Amigos! that provides group walking programs and is effective in reducing loneliness and improving mental health for Latino older adults.[8] A one-size-fits all approach to reducing loneliness in later life during the pandemic is unlikely to be most effective or acceptable to older adults. Rather, considering personalized contributing factors to loneliness as well as factors that impact ability and willingness to engage in an intervention may result in the best outcomes.

While the article by Sams et al. focused on community-dwelling older adults with at least some technology access (as the study was completed online), it is important to consider other groups vulnerable to loneliness during the pandemic and that contributing factors to loneliness might differ for these groups, including older adults in long-term care facilities[9] and older adults in rural areas.[10] In addition to financial insecurity, physical health, and resilience—factors studied by Sams et al.—other factors have been shown to increase risk for loneliness and distress during the pandemic, including psychological factors such as subjective age.[11] Future work that integrates findings across studies while considering contexts such as culture, rurality, SES, and care setting could further our understanding of how to best reduce loneliness in older adults and thereby promote health and well-being.

AUTHOR CONTRIBUTIONS

Kim Van Orden is responsible for the entire manuscript.

DISCLOSURE

Kim Van Orden has no conflicts of interest to disclose.

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