Chapter 17

Loneliness during the COVID-19 pandemic

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Introduction

The COVID-19 pandemic has direct effects on people's health and the number of deaths due to the virus has reached more than a million (WHO, 2020a). In addition, the pandemic and society's response to the pandemic have indirect effects on people's lives – sometimes discussed in terms of collateral damage. Loneliness is one potential indirect effect. This editorial aims to consider how loneliness among older adults can be understood in the light of the COVID-19 pandemic and interventions to reduce loneliness.

Loneliness is a negative feeling arising from a perceived discrepancy between a person's desired and achieved social relations (Perlman & Peplau, 1981), e.g., their number, frequency or quality. By comparison, social isolation is an objective state measured via indicators such as living alone, few or infrequent social contacts and low levels of social activity. Numerous studies have shown that social isolation is a risk factor for loneliness (Dahlberg, McKee, Frank, & Naseer, 2022), which itself is associated with an increased risk of poor health, low well-being and mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Leigh-Hunt et al., 2017; Rico-Uribe et al., 2018).

In order to minimise the spread of COVID-19 many governments have enforced restrictions on physical social contacts, ranging from recommendations to keep a physical distance from others to lockdowns of communities and even whole societies. Older adults have been identified as being at higher risk of poor outcomes if infected (WHO, 2020b) and in many countries have been subjected to greater restrictions on their physical contacts with others.

Loneliness during the pandemic

Several studies of the general population have found an increase in loneliness since the outbreak of COVID-19 (e.g., Ausin, Gonzalez-Sanguino, Castellanos,

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& Munoz, 2021; Bu, Steptoe, & Fancourt, 2020; Elran-Barak & Mozeikov, 2020), especially among younger people (Bu et al., 2020; Li & Wang, 2020), although there are also reports of fairly stable levels of loneliness (Luchetti et al., 2020; McGinty, Presskreischer, Han, & Barry, 2020).

Regarding older adults, most evidence points towards an increase in loneliness during the pandemic. Studies focusing on older adults in the United States (US), the Netherlands and Austria have found an increased or high level of loneliness during the pandemic (Emerson, 2020; Kotwal et al., 2020; Krendl & Perry, 2021; Stolz, Mayerl, & Freidl, 2021; van Tilburg, Steinmetz, Stolte, van der Roest, & de Vries, 2020). Similar results have been reported in studies of specific groups of older adults in a number of countries, including psycho-oncology patients (Schellekens & van der Lee, 2020) and residents of long term care facilities (Van der Roest et al., 2020) in the Netherlands, people with multimorbidity in Hong Kong (Wong et al., 2020), and members of an organisation for older adults in the US (Gaeta & Brydges, 2020). There are contrasting findings: a study of older adults in Israel found low levels of loneliness (Shrira, Hoffman, Bodner, & Palgi, 2020) and a study of younger older adults (aged 65–71 years) in Sweden found no change in levels of loneliness (Kivi, Hansson, & Bjälkebring, 2020).

However, there are limitations to most studies on COVID-19 and loneliness published to date. First, the majority use convenience sampling and/or collected data online, which is likely to underrepresent the oldest old, older adults with low or no Internet usage, and those in poor health. Studies with more representative samples include those by Kivi et al. (2020; albeit with a younger age group) and van Tilburg et al. (2020). Second, the studies tend to not have a prospective design including data collected before the pandemic, with consequently limited potential to attribute changes in loneliness to factors related to the pandemic. Third, many studies were undertaken a short time into the pandemic, thus limiting their contribution to understanding how loneliness develops over the course of a pandemic and its effects on health and well-being. Finally, with few exceptions (e.g., Whatley, Siegel, Schwartz, Silaj, & Castel, 2020) the studies lack an explicit theoretical foundation. To ensure that policy during this and future pandemics is guided by reliable evidence, more studies are needed that have a solid theoretical foundation, of prospective design with representative samples of older people and of sufficient duration to examine both short- and long-term effects of the pandemic.

Understanding loneliness during the new normal

There are several theoretical perspectives on loneliness (see, e.g., de Jong Gierveld & Tesch-Römer, 2012; Perlman & Peplau, 1982). Two key perspectives are the cognitive perspective and the resource perspective.

From a *cognitive perspective*, loneliness can be understood as a result of unmet standards of social relations and activity, i.e., a discrepancy between

desired and achieved social relations (Tesch-Römer & Huxhold, 2019). One study carried out during the pandemic found that emotional loneliness increased in those who had experienced a loss of social contacts and activities, but found no effect on social loneliness when contact frequency decreased (van Tilburg et al., 2020). The authors suggest that physical distance measures may have lowered the expectations of frequency and exchange in social relations. It has also been argued that such measures might induce a feeling that "everyone is in this together" (Luchetti et al., 2020, p. 10), which may buffer against an increase in loneliness as long as the measures are adhered to collectively.

People vary in their social standards, which partly explains why the level of loneliness varies between individuals with objectively the same level of social contacts (Tesch-Römer & Huxhold, 2019). From this perspective, people whose standards include a socially active life would be expected to experience a greater increase in loneliness during enforced physical distancing than would people whose standards for a socially active life are lower. However, to date there has been no test of this hypothesis in research during the pandemic.

Social standards are also related to the culture in which people live. For example, it has been found that loneliness is more common in collectivistic societies in Southern and Central Europe than in individualistic societies in Northern Europe (Fokkema, Gierveld, & Dykstra, 2012; Lennartsson, Rehnberg, McKee, & Dahlberg, 2020). One would expect a greater increase in loneliness during the pandemic in collectivistic cultures with higher desired levels of social relations than in individualistic cultures. However, while studies have been carried out in different countries, no comparative research on loneliness in older adults during the pandemic has yet been published. This also means that the effect of different governmental responses to the pandemic has not been examined.

The *resource perspective* may contribute further to the explanation of loneliness during the pandemic. According to this perspective, an individual's access to resources affects loneliness directly but also via its influence on social relations and social activities (Tesch-Römer & Huxhold, 2019). Resources can be divided into individual and contextual material resources (e.g., socio-economic status, health and socially responsive neighbourhoods) and individual non-material resources (e.g., communication and social skills) (Tesch-Römer & Huxhold, 2019).

In line with this perspective, older adults with access to more resources would be expected to manage restrictions during the pandemic better and be less prone to increased loneliness. Although this hypothesis has not been explicitly tested, loneliness during the pandemic has been found to be associated with material resources such as lower income (Whatley et al., 2020) and poor physical and mental health (Kotwal et al., 2020; Krendl & Perry, 2021; Parlapani et al., 2020; Robb et al., 2020; Shrira et al., 2020; Wong et al., 2020). Furthermore, loneliness is more common in individuals living alone

(Parlapani et al., 2020; van Tilburg et al., 2020; Wong et al., 2020), with infrequent social contacts (Gaeta & Brydges, 2020; van Tilburg et al., 2020), and whose support needs are not being met (van Tilburg et al., 2020).

Reducing loneliness during the pandemic

So, how can we prevent increases in loneliness due to the pandemic? Unfortunately, reviews of interventions targeting loneliness in older adults have repeatedly noted that there is little evidence for what interventions and what elements of interventions are effective (for an overview of reviews, see Victor et al., 2018). In addition, a recent evidence map of social services for older adults found that there is a lack of research regarding how social services meet social needs (Dahlberg, Ahlström, Bertilsson, & Fahlström, 2019).

Many interventions to reduce loneliness are based on group activities, which in the current uncertain situation are not easily arranged and often cancelled or even forbidden. While keeping physical distance does not mean that it is impossible to have social contacts, there are barriers to creating safe conditions for social interactions inclusive for all. For example, physically frail individuals may require support to meet outdoors, and the use of personal protection equipment may be confusing and distressing for those with cognitive impairments.

From a theoretical perspective (Carstensen, Fung, & Charles, 2003; Freund & Baltes, 1998), older adults who during the pandemic are best able to focus on and optimise key social relations and compensate in some way for the loss of social contacts should be best equipped to adapt to the prevailing conditions. One way that older adults could compensate for the loss of physical social contacts is via technology. There is evidence that social technologies have the potential to reduce loneliness in older adults (Poscia et al., 2018), particularly if used as a means to enhance existing and form new relationships rather than replace offline relationships and activities (Fan, 2016; Nowland, Necka, & Cacioppo, 2018). Relations at a distance do not, however, provide the same significance and value as face-to-face or tactile contacts in all situations, for example when a person is emotionally distressed. From the resource perspective a narrow focus on technology-based interventions is also problematic. There are digital divides, with evidence that some older adults experience digital exclusion (Seifert, Hofer, & Rossel, 2018) and with structural barriers in terms of internet and/or broadband access in some regions (Spoor, Tasciotti, & Peleah, 2014). Limited economic resources will hinder the use of social technology, as will cognitive and physical impairments and poor health (Fan, 2016; Tavares, 2020). Barriers to deliver interventions remotely also include, e.g., older adults' attitudes and skills regarding technology as well as the involvement of other individuals for interaction, training and support (Gorenko, Moran, Flynn, Dobson, & Konnert, 2021). Traditional methods of maintaining social relations at a

distance, such as telephones, are of course still available and have been used in interventions during the pandemic (van Dyck, Wilkins, Ouellet, Ouellet, & Conroy, 2020).

There has been less focus on non-technological ways of combating loneliness during the pandemic. The outdoor environment is an important venue for social contacts (see Burholt et al., 2020). In societies with physical distancing recommendations but without orders to stay at home, supporting neighbourliness and community use of local open spaces could help to prevent increases in loneliness. Again, a resource perspective on loneliness is relevant, as loneliness is less common among people living in better resourced, safer and physically accessible neighbourhoods (Gibney, Zhang, & Brennan, 2020)and the likelihood of living in a deprived neighbourhood is higher among people with less financial means (see Tesch-Römer & Huxhold, 2019).

Finally, on a policy level, the imposition by many countries of greater restrictions on physical contacts for older adults than for other members of the population reveal an ageist view of older adults as a homogeneous group. While the risk of negative outcomes if infected with COVID-19 is correlated with higher age, resources such as health and access to care vary in the older age group and result in divergent risk profiles. A more nuanced and ageist-proof policy response to the pandemic is needed in order to avoid unnecessary collateral damage such as increased loneliness in older adults.

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