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The Loneliness of Aging

Author: Joan Somes, PhD, RN-BC, CEN, CPEN, FAEN, NRP, Apple Valley, MN
Section Editor: Joan Somes, PhD, RN-BC, CEN, CPEN, FAEN, NRP

Abstract

Isolation and loneliness have become buzz words when discussing older adults during the coronavirus disease pandemic; yet, these are age-old problems. Both have been studied extensively, yet there currently is no rapid or succinct tool that can be used in the emergency department to screen for either, or a consensus of evidence-based ways to correct these issues. This is of concern because both loneliness and social isolation have been linked to poor health. Poor health, in turn, can lead to worse isolation and loneliness. These health problems may lead to the older adult seeking care in the emergency department where screening and initial treatment could be initiated. Suggestions for questions that emergency nurses can ask to identify an older adult who is lonely or suffers from social isolation, as well as steps to consider when encountering the older adult with complaints of loneliness and/or social isolation, are provided, with the realization that these are only the first steps of many that would need to be taken. The purpose of this article is to bring forward updated information that discusses loneliness and social isolation in older adults, a timely priority during the coronavirus disease pandemic and often listed as a factor in older adult deaths. A review of relevant screening tools for use in the emergency department are provided.

Key words: Aged; Social isolation; Loneliness; Surveys and questionnaires; Emergency nursing; COVID-19

Isolation and loneliness have been written about and studied for centuries and are not new problems.2-5 However, the COVID-19 pandemic has led to renewed concerns about social isolation and loneliness and how to deal with them. It seems appropriate to take a look at both, including some of the causes, the effects they have on health, and some options that emergency nurses could consider when providing care for the older adult who is at risk of social isolation and loneliness, now and even after COVID-19 is not the causative factor.

Although social isolation may lead to loneliness, these terms are not interchangeable.2-5 Loneliness is described as the subjective feeling of distress related to the patient’s perception of a lack of companions or social connections/network.3,4 Isolation is the objective description of a lack of social connections.3,5 Previous studies have discussed older adults (typically aged above 65 years) who identified as socially isolated but were not suffering a sense of feeling lonely and others who complained of feeling lonely although they were not socially isolated.1-8 The studies also noted that life events that accompany aging increase the risk of an older adult becoming disconnected from society and vulnerable to developing social isolation and/or feelings of loneliness.3,7-11 It is important for emergency care providers to recognize the older adult who is at risk of being lonely or socially isolated because both have been
linked to poor health outcomes. More importantly, there are actions that can be taken to mitigate these issues.

Risk Factors for Social Isolation and Loneliness

The most commonly identified risk factor leading to isolation and loneliness is the death of a spouse, significant other, or friend(s)—especially when the loss involves a support person or means of transportation. Other easily recognized risk factors involving loss include loss of family involvement when children grow up, leave home, and become busy with their own lives, or a loss of the neighborhood network of friends that occurs during the process of downsizing or relocating to a smaller home, condominium, assisted care, or nursing home. Retirement can also lead to loss of daily interaction with coworkers and friends, leading to loneliness. Becoming a primary caregiver can lead to loss of time to socialize, to isolation, and to a sense of loneliness in the caregiver, especially if the ailing person in the partnership was the one who did the driving before becoming ill.

Other losses related to aging may or may not immediately be recognized as the causative factor in the loneliness or isolation experienced by an older adult. Loss of the ability to drive owing to physical or cognitive changes, as well as worries about safety when driving or the lack of alternative transportation can lead to decreased opportunities for socialization. Extreme weather causing snowy/icy roads and sidewalks, excessive heat, humidity, or air pollution, as well as fears of falling, increased crime, and personal safety (especially related to infections—flu and COVID-19) have been listed as reasons to remain homebound and thus at risk of isolation and loneliness.

Increased frailty, mobility issues, and lack of funds to cover the cost of socializing (e.g., eating out with friends, going to movies, playing bingo) as well as concerns about being embarrassed or becoming an embarrassment in public have led to older adults staying isolated in their home to avoid these situations. The need to rely on durable medical equipment (oxygen tanks, walkers, wheelchairs, and so on) and inability to hear what others are saying or see what others are seeing can also lead to older adults staying home.

Ageism and stereotyped thinking or comments such as “They are old, so…they won’t want to,…they can’t keep up,…they’d rather be in bed,…they need frequent restroom stops,…they can’t hear,…they can’t see,…they won’t understand the situation” are attitudes that have led to older adults not being invited to attend social events or to their own reluctance to attend, thus leading them to be socially isolated. Worse yet is when the older adult is brought to an event but ignored by the rest of the people in attendance owing to these attitudes. Vulnerable older adults who are also first-generation immigrants have identified increased isolation owing to language barriers, and the lesbian, gay, bisexual, transgender population has reported loneliness more than other groups.

It is easy to recognize the “common” reasons for an older adult to feel disconnected, socially isolated, and lonely (loss of spouse or friends). When obtaining a history to identify the older adult who is lonely or isolated, it is important to consider other aspects of the older adult’s life that allow or disallow the ability to interact with others. It is not only the physical loss of significant others or friends that puts one at risk; it may be a change within the older adult’s self-image or the way they are being treated that leads to loneliness and isolation. Even after the fears of exposing our older adults to COVID-19 has gone away, these other reasons will remain and may even be perpetuated in our emergency departments.

The Risks of Isolation and Loneliness

The multiple health risks associated with social isolation and loneliness make it important for health care providers to identify older adults who are isolated or lonely and attempt to intervene. Singer notes that most people are “physiologically and biologically ‘programmed’ to need social networks.” Loss of the ability to network can lead to stress build-up and release of cortisol, which leads to an inflammatory response in the body and associated consequences. Studies have shown increased platelet aggregation, instability of the autonomic nervous system, hypertension, arthritis, anxiety, depression, and suicidal ideation in persons reporting feelings of being isolated or lonely.

The risk of cardiovascular death increases by 90%, the risk of death from an accident or suicide attempt has been shown to double, the risk of having a nonfatal coronary event in the lonely or isolated older adult increases by 29%, the risk of having a stroke by 32%, and the risk of developing dementia by 50%. One study equated the effects of loneliness and isolation on the body to the equivalent of smoking 15 cigarettes a day. Patients with heart failure and loneliness had a 4-times-greater risk of death, 68% more hospitalizations, and presented to the emergency department on a more frequent basis (57%). The ability to fight off infections is reduced owing to decreased immune system activity, and declines in renal function have also been associated with isolation and loneliness. Poor sleep patterns, signs of accelerated cognitive decline, and a diminished ability to carry out activities of daily living have been seen in those who are isolated and lonely. Living alone may contribute to poor eating, increased use of alcohol, and
increased risk of elder abuse (scams and fraudulent financial schemes).<sup>7,8,12</sup> Premature death risk overall doubles in the patient who is lonely and isolated.<sup>13</sup>

Approximately one-fourth of adults aged above 65 years are considered to be lonely or socially isolated. Living alone, loss of friends and family, chronic illness, and hearing/vision loss are identified as the most common factors causing this.<sup>7,13</sup> It is interesting to note that although isolation and loneliness can contribute to poor health, poor health can also contribute to social isolation and loneliness.<sup>3-5,11,18,19</sup> Identifying the older adult who is lonely or socially isolated and intervening may help to break this cycle.

### Screening Tools Looking for Social Isolation and Loneliness

When looking at the number of adults aged above 60 years who admit to being lonely (25%-50%)<sup>3,5,7,9</sup> and/or socially isolated (24%-30%),<sup>3,5,7,11</sup> combined with the risks of the serious medical consequences attributed to loneliness and social isolation, it would seem appropriate to identify a quick and simple screening tool that emergency nurses could use to identify those older adults who are at risk. ED staff could then work to incorporate some sort of “fix” into these patients’ plan of care to improve health outcomes.

In a meta-analysis comparing tools to measure loneliness and social isolation, Valtorta et al identified 54 instruments.<sup>18</sup> The number and variety of questions found in the various screens were numerous, wide-ranging, and not standardized. Ultimately, Valtorta et al concluded that the questions found in the various screens could be simplified and classified as either the “function and structure of a social relationship” or the “degree of subjectivity related to the relationship,” but none of the tools screened for both. Their recommendation was to use a screen that was specific to the problem being studied: social isolation or loneliness.<sup>4</sup> It was also noted by Valtorta et al, as well as other authors during their literature reviews, that the studies looking at loneliness and social isolation frequently lacked standardization of terminology, often did not include all the interdependent variables (isolation, loneliness, and underlying health status), and that the subjective nature of the answers related to loneliness questions compared with the objectively measured answers to social isolation questions led to challenges identifying/creating 1 tool to use.<sup>3-5,11,18,19</sup> In addition, many studies’ screening questions did not ask about health, whereas others focused entirely on the concept that social isolation and loneliness led to poor health and that poor health contributed to isolation and a sense of loneliness.<sup>3-5,11,18,19</sup> Valtorta et al also specifically noted that most screening tools went into such depth that they took significant time to complete. Currently, there is no standardized, succinct, meaningful, and evidence-based tool that screens for both loneliness and social isolation to identify the older adult suffering from, or at risk for, these conditions in the emergency department. However, there are programs that may be helpful in identifying the potential risk of, and dealing with, social isolation and loneliness.

The Campaign to End Loneliness, started in the United Kingdom in 2011, provides a potential solution to screening.<sup>18</sup> The program has since expanded to several countries across Europe and to some degree in the United States.<sup>18</sup> The goal of the campaign was to decrease loneliness and social isolation in the “elderly population” in the United Kingdom.<sup>18</sup> In 2013, the project leaders determined that a simple screening tool was needed to measure the successes related to the interactions that had been implemented. A variety of measurement tools, including the De Jong Gierveld loneliness scale, the revised UCLA loneliness scale, and the single-item “scale” were evaluated.<sup>18</sup> The campaign leaders concluded that each of these 3 tools had their benefits, but each also had a downside (2 were more appropriate for researchers; the other was better designed to determine if services were needed by the older adult or if the services being provided were sufficient).<sup>18</sup> The Campaign to End Loneliness leaders then decided to create their own tool that synthesized and incorporated the concepts of the many screens found in the literature.<sup>18</sup> Care providers were instructed to review information about each of the loneliness scales to determine which was most appropriate for their clientele and use the tool that best served their project.<sup>18</sup> (See Table 1 for components of the scales.)

When distilled down, most of the tools ask participants about feelings related to (1) having enough friends and relationships, (2) being able to trust/rely on people for help at any time, and (3) whether their relationships were as satisfying/inclusive as they would like.<sup>18</sup> Each screen calculated a score, but the leaders of the campaign reminded caregivers that the scores were a “snapshot” of the moment and only compared how the person is changing in their loneliness, not how lonely they are compared with someone else. They also noted that “someone with a score of ‘4’ may not be half as lonely as the person with a score of ‘8.’”<sup>18</sup> A search to see if the United States had a version of the Campaign to End Loneliness program led to the Health Resources and Services Administration website, which provided data about loneliness in older adults and a link to the Campaign to End Loneliness in the United Kingdom.<sup>14,18</sup>

Emergency nurses who would like to quickly screen for loneliness in their ED patient could use the De Jong Gierveld loneliness scale, revised UCLA loneliness scale, single-
item “scale,” the Campaign to End Loneliness Measurement Tool,18 or simply ask the patient if they are feeling lonely. It should be noted that none of these tools measures the risk of social isolation, and not all have been validated or universally used, but the answers would give emergency nurses a general sense of how the patient feels that they are doing in regard to feeling lonely.18

Social isolation is distinctly different from loneliness.3-13,18,19 Living alone was the most common factor associated with social isolation, and almost 50% of the older adults lived alone.9,11,12,19 It is important to note that although someone who is socially isolated may have a high loneliness score, there are just as many who meet the definition of “socially isolated,” yet are able to develop and maintain a network of contacts and connections and thus say that they do not feel lonely.11,19

The Lubben Social Networking Scale was most frequently mentioned when searching for tools that screened for isolation.20 The National Social Life, Health, and Aging Project provides a list of indicators identified as potentially helpful in determining the risk of social isolation, although it is not specifically identified as a screening tool.21 The American Association of Retired Persons (AARP) Foundation’s “Framework for Isolation in Adults Over 50” provided a meta-analysis of tools used to measure isolation and loneliness, noting that tools related to measuring isolation were limited.19 The AARP provided a list of individual measures useful in gauging isolation, with the notation that “isolation in adults age ≥50 years occurs due to a complex set of circumstances and factors at the individual, social network, community, and societal levels.”15 Living alone, mobility or sensory impairments, major life transitions, limited resources, language barriers, location, and low income were identified as some of the factors that affect the ability to connect with other people.19-21 (See Table 1 for a list of indicators.) The AARP authors also noted that health status can have an impact on the ability to connect with others and that all factors contributing to social isolation can also contribute to loneliness.19 Finally, the AARP authors noted that variations in how researchers described, defined, and measured work on isolation demonstrated that “additional research would be helpful in standardizing tools and interventions.”19

As noted, there are currently no simple screening tools that can be used in the emergency department to identify the older adult suffering from, or at risk for, both loneliness and social isolation. However, asking basic questions about living alone; the number of social or family contacts; and the patient’s satisfaction with quantity, quality, reliability, and trust of these contacts, as well as asking the older adult if they feel isolated or lonely may provide enough information to lead emergency nurses to take action.

### Actions To Take When a Patient Is Lonely or Socially Isolated

Interestingly, no specific interventions related to loneliness or social isolation have been proven to be effective in the long term, especially related to improving health.3-6,18,19 In the words of 1 study’s author, there is a “dearth” and “paucity” of studies that are well constructed, evidence-based, or replicated that describe the actions to
take when a patient is lonely or socially isolated. The Agency for Healthcare Research and Quality released a study in 2019 that looked at interventions targeting social isolation and loneliness, as well as their impact on health in those aged above 60 years. Their key messages noted a lack of consistency in terminology, screens and measurements being used, effects of interventions, adverse events as a result of interventions, and follow-through by investigators in their reports. These sentiments were echoed in other meta-analyses reviewing this critical issue of loneliness and social isolation. Despite being in the forefront during the COVID-19 pandemic, concern regarding dealing with loneliness and isolation in the older adult is not a new concept, and evidence-based solutions to the problem are still being sought.

### What Can Emergency Nurses Do?

Despite a lack of standardized screens and proven methods of approaching loneliness and isolation in the older adult, emergency nurses can ask questions of the patient about feelings of loneliness or being socially isolated and take actions to help mitigate risk to an older adult’s health caused by these issues. It should be recalled that social isolation and loneliness are multifactorial; therefore, a variety of solutions should be considered when attempting to assist the older adult to reengage with others, overcome the risks of isolation and loneliness, and decrease the risks placed on their health. Emergency nurses can make a difference by simply asking the older adult, “How are you doing? Do you live alone? Do you feel lonely or isolated? Do you feel you have the help you need and trust? Do you get to visit with someone you like?” Then, the emergency nurse can take some steps to help reconnect the older adult.

The Campaign to End Loneliness document, as well as the AARP “Framework for Isolation in Adults Over 50” and the 2019 Agency for Healthcare Research and Quality document, all provided ideas that could be employed to combat loneliness and social isolation. Many of these solutions include:

### TABLE 2

**Examples of ways to increase connections, decrease loneliness, or isolation**

1. Spend quality time and connect with the older adult when they are in the department as a patient. (Remember that difficulty hearing can cause additional disconnection.)
2. If your department does patient call backs - take the time a make that call to an older adult and re-connect with them. These call backs were shown to be decrease sense of loneliness and isolation.
3. Work with the provider to obtain a referral for a home visit to check on the patient. Provide documentation that validates the ICD-10-CM codes application.
4. Talk with family about safe ways to do face-to-face visits through windows or patio doors. Once a week is recommended.
5. Provide resources listing agencies in the area that can help with transportation, respite care, meals on wheels, or other social activities or ways to connect with other seniors.
6. Promote positive thinking, meditation, appropriate physical exercise, and breathing exercises.
7. Ask if they have considered getting a pet if appropriate.
8. Provide education to staff and family that addresses attitudes and stereotypes about older adults with a goal to decrease ageism and shunning while increasing connecting with the older adult.
9. Provide and demonstrate how to use new technology – video apps, etc. so the older adult can connect with others via on-line video systems.

### TABLE 3

**Apps for Mobile, Tablet or Desktop Video Chat**

| Apps for Mobile, Tablet or Desktop Video Chat |
|-----------------------------------------------|
| Zoom                                         |
| Skype                                        |
| Facetime                                     |
| Google Hangouts                              |
| Google Duo                                   |
| WhatsApp                                     |
| Facebook Messenger                           |
these, as well as other options gleaned from the literature that emergency nurses could consider when attempting to increase connections, decrease loneliness, and lessen social isolation in the older adult, are listed in Table 2.

During an ED visit, the nurses can help keep the older adult who complains of feeling lonely or socially isolated “connected” by spending some extra time talking with the patient and connecting the patient with family using technology (eg, video chatting applications Table 3). When it is again safe to do so, nurses can create a cadre of volunteers who can sit and visit with a lonely or isolated older adult during their ED visit. Emergency nurses can also maintain lists of senior events, ride-share programs, and other volunteer opportunities that can be shared with older adults. The nurses can also connect the lonely/isolated older adult with meals-on-wheels programs, senior centers, local churches, or other senior activities in their community that may help to keep them from feeling isolated or lonely. Some emergency departments make follow-up calls to check on patients seen in the department. This is an excellent opportunity to reconnect with the older adult and decrease that sense of loneliness or isolation. It is also recommended in the American College of Emergency Physicians’ Geriatric Emergency Department Accreditation Criteria as a way to improve geriatric care.22

Emergency nurses should work with the ED provider to obtain a follow-up referral for the older adult who is at risk of being isolated or complains of being lonely. Emergency nurses should document information that validates the need for referrals and additional care on discharge. The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Z codes include categories that capture social determinants of health and things that affect patient health but are not necessarily a specific disease or injury.23,24 “Problems related to living alone” (ICD-10-CM Z60.2) has been used to obtain additional services for the older adult who is lonely or isolated.23,24 ICD-10-CM codes Z55 to Z65 identify additional socioeconomic or psychosocial circumstances (living alone, feeling lonely, mobility/communication issues, and so on) that may influence patient health status and provide validation for additional contact with other health services that can be helpful for the older adult who is lonely or socially isolated.23,24

Although there are currently no rapid screening tools or long-term “fixes” for loneliness and social isolation in the emergency department, it is important for emergency nurses to ask a few pointed questions and identify the older adult patient with minimal social contacts or connections, physical limitations, and living situation that places them at risk of loneliness or social isolation. If seeing a risk, set into motion actions that will help the older adult be more connected, less isolated, less lonely, and ultimately healthier. These actions may not be the final “fix,” but they can be the first steps to correcting social isolation and the loneliness of aging.

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For presubmission guidance, contact Joan Somes, PhD, RN-BC, CEN, CPEN, FAEN, NRP at: someswasblackhole@gmail.com. Submit a manuscript directly to JEN.