Addressing Loneliness in the Era of COVID-19

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Prolonged loneliness is a major yet underappreciated determinant of health, placing individuals at greater risk of premature death than obesity, inadequate physical activity, or air pollution. With more adults than ever before living alone and a large proportion of older adults without access to online connectivity tools, the US has a dangerously fertile environment for an epidemic of loneliness caused by coronavirus disease 2019 (COVID-19) social distancing strategies. Groups at especially high risk include older adults, low-income individuals, and those with preexisting mental illness. Although social distancing is critical to mitigating COVID-19 transmission, the health care system should play a leading role in identifying, preventing, and alleviating loneliness and associated health risks during the pandemic.

Loneliness Is a Core Determinant of Health

Loneliness is the subjective perception of a deficit in social connection; social isolation, in contrast, is an objective measure based on social network size or frequency of social interactions. Left unchecked, loneliness can become a potent risk to physical and mental health. In a 2015 meta-analysis of 70 cohort studies, lonely individuals had a 26% increased likelihood of nonsuicide death over a mean follow-up of 7 years. This association is likely mediated by factors such as hypothalamic-pituitary-adrenocortical activation, impairments in sleep quality, and increases in systolic blood pressure. Large cross-sectional studies have linked loneliness to higher rates of anxiety, depression, and suicidal ideation, although the causal direction of this association remains unclear. In older adults, loneliness and cognitive decline are closely related.

Potential Effect of the COVID-19 Pandemic on Loneliness

The COVID-19 pandemic is likely exacerbating loneliness by drastically reducing routine and intimate interactions and substituting face-to-face contact with modes of communication that may increase loneliness, such as social media. Several populations are at increased risk. Older adults may have less access to, or facility with, videoconferencing tools that assist in maintaining social contact. To protect vulnerable residents from COVID-19, nursing homes have implemented Centers for Disease Control and Prevention guidelines to restrict visitation and cancel group activities and communal dining. Such social restrictions in nursing homes will likely be among the last to be lifted.

Loneliness also is more prevalent among low-income individuals, who are less able to work remotely and thus more likely to lose employment. Unemployment, in turn, may worsen loneliness through a variety of mechanisms, from the loss of workplace social ties to shame induced by losing one’s source of income and social role. Those with mental illness already experience higher loneliness rates, and these rates may increase further owing to loss of routines, feelings of powerlessness and anxiety, and diminished access to mental health services.

A Public Health Framework for Addressing Loneliness During COVID-19

In late February, 3 weeks before many states announced stay-at-home orders, the National Academies of Science, Engineering, and Medicine released a report that outlined the role of the

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health care system in addressing loneliness in older adults.\textsuperscript{5} The report's recommendations have taken on new significance with the advent of social distancing, and they must now be adapted to current circumstances. We highlight the recommendations that are actionable in the short term, adaptable to individual patient characteristics, and mindful of the strain imposed by COVID-19 on health care capacity.

Primary prevention should aim to eliminate preventable risk factors for loneliness by identifying and remedying potential barriers to communication. Sensory impairments are a preventable cause of loneliness in older adults and may be addressed with the provision of equipment such as hearing aids. Nursing homes and local home care agencies should ensure residents’ access to videoconferencing software to facilitate communication with friends and relatives. Elder service organizations, advocacy groups, and relevant government agencies should collaborate to disseminate research and share examples of best practices for maintaining social connection within the constraints imposed by COVID-19, adapting established approaches such as the UK Campaign to End Loneliness.\textsuperscript{5}

Secondary prevention efforts should focus on identifying loneliness and enhancing supports to prevent further progression. Rather than screen universally for loneliness, the National Academies report recommends that clinicians use clinical judgment and risk stratification to identify patients who would benefit from an assessment (eg, those experiencing major life events, such as job loss).\textsuperscript{5} Health care teams may assess patients for loneliness using validated tools, such as the 3-item UCLA Loneliness Scale. This scale was developed for use in telephone surveys and is frequently used in both clinical and research settings. When loneliness is identified, clinicians should assess for comorbidities, such as depression and cognitive impairment, and collaborate across sectors to provide targeted social support. Physicians may use social prescribing to navigate lonely patients toward social services and community-based organizations, which may both alleviate loneliness and address essential needs, such as food insecurity. New forms of social support offered by grassroots volunteer organizations are now available, including video-mediated friendly visits for older adults. Finally, clinicians should prioritize lonely patients for virtual visits to ensure continuity of care, given that routine health care visits often represent a primary point of social contact for these patients.

Lastly, tertiary prevention should focus on major complications of unaddressed loneliness, such as suicidality and substance use. Expansion of key services, such as telehealth counseling, will enable more effective surveillance and mitigation of these outcomes, but in-person psychiatric evaluation or hospitalization will remain necessary for some patients and should be balanced against COVID-19 risks. Additional research is urgently needed to reduce adverse consequences of loneliness and psychosocial distress under the unique constraints imposed by the COVID-19 pandemic.\textsuperscript{7}

Physicians and other health care professionals cannot “fix” loneliness in the same way they treat more discrete problems in clinical practice. Nor should they; loneliness is not a disease to be vanquished, but a useful personal barometer of social needs that must be addressed to enhance connectedness and prevent adverse health outcomes. Long-term approaches to loneliness will likely require major changes to social structures and attitudes. During and after the COVID-19 pandemic, however, clinicians, researchers, and health care systems can play a leading role in expanding assessments, interventions, and research to reduce health risks associated with loneliness.
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