REVIEW

Loneliness Among the Elderly: a Mini Review

Одиночество человека в пожилом возрасте: краткий обзор

doi: 10.17816/CP143

Review

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ABSTRACT

Loneliness is understood as a painful negative emotion. Since its introduction into the psychiatric literature in 1959, the understanding of loneliness has improved considerably, and is now understood to be a distinct entity to such issues as social isolation, solitude, and depression. However, there is still a lack of consensus on the general definition of loneliness. Similarly, different dimensions of loneliness have been described in the literature. It is understood in terms of either transient versus situational versus chronic loneliness; state versus trait loneliness; and the concept of unidimensional versus multidimensional loneliness. The reported prevalence of loneliness varies considerably in the literature, with evidence from metanalysis suggesting the prevalence of moderate loneliness that ranges from 31 to 100% with a mean of 61%, and that of severe loneliness ranging from 9 to 81%, with a mean prevalence of 35% among the elderly. Loneliness among the elderly is associated with significant adverse mental and physical health outcomes in the form of cardiovascular diseases, stroke, diabetes mellitus, arthritis, depression, anxiety, dementia, and even problematic internet use. Over the years, different instruments [University of California Los Angeles Loneliness Scale (UCLA-LS), De Jong Gierveld Loneliness Scale, Single-Item direct measure of loneliness] have been designed to assess loneliness among the elderly. Some of the interventions suggest that persons experiencing loneliness could benefit from improved social skills, enhanced social support, increased opportunities for social contact, and addressing maladaptive social cognition.

АННОТАЦИЯ

Одиночество — болезненное состояние, сопряженное с отрицательными эмоциями. С момента появления термина в психиатрической литературе в 1959 году понимание одиночества значительно улучшилось. На сегодняшний день его считают самостоятельной нозологической единицей и воспринимают отдельно от социальной изоляции, уединения и депрессии, однако согласованного определения одиночества до сих пор нет. В литературе описаны различные параметры одиночества: разделяют временное или ситуативное одиночество и одиночество хроническое; одиночество может расцениваться как самостоятельное состояние или как проявление другого состояния; также одиночество может восприниматься как концепция, характеризующаяся одним или множеством параметров. Распространенность одиночества, по данным литературы, существенно варьирует: результаты метаанализа свидетельствуют о том, что распространенность умеренно выраженного одиночества составляет от 31% до 100% (при среднем значении 61%), а распространенность тяжелого одиночества — от 9% до 81% (при среднем значении 35% среди пожилых людей). Одиночество у пожилых людей сопряжено со значительными неблагоприятными последствиями для психического и физического здоровья, которые выражаются в виде сердечно-сосудистых заболеваний, инсульта, сахарного диабета, артрита, депрессии, тревоги, деменции и проблем с использованием интернета. За последние годы для оценки одиночества среди пожилых людей были разработаны различные инструменты [Шкала оценки одиночества

Калифорнийского университета в Лос-Анджелесе (University of California Los Angeles Loneliness Scale, UCLA-LS), Шкала оценки одиночества де Джонга Гервельда (De Jong Gierveld Loneliness Scale), однокомпонентный инструмент, направленный на непосредственную оценку одиночества]. Некоторые вмешательства, предлагаемые для коррекции состояния лиц, испытывающих одиночество, включают совершенствование социальных навыков, усиление социальной поддержки, расширение возможностей для социальных контактов и устранение дезадаптивного социального познания.

Keywords: *loneliness; consequences; assessment*
Ключевые слова: *одиночество; последствия; оценка*

INTRODUCTION

Today, loneliness appears to be becoming ubiquitous. The importance of loneliness can be understood from the fact that the Government of the United Kingdom appointed a Minister for Loneliness in 2017, followed by a similar move by the Government of Japan in 2021. It is now understood to represent a 'hidden killer' and has been shown to have a significant negative impact on both mental and physical health. It is known to be associated with high morbidity and mortality. Loneliness has been reported across all age groups, although it has been most commonly studied among the elderly.

This brief review discusses the concept of loneliness among the elderly and the suggested interventions to address it.

CONCEPTUAL ISSUES

The word "loneliness", which is understood to be a painful negative emotionality due to the perceived lack of social connectivity, first appeared in the literature in the 1800s [1]. Prior to the use of the term 'loneliness', the closest concept was 'oneliness', which meant being alone though without the negative connotation of lack of emotions [1]. It is said that earlier, God was always with people, who were hence never truly alone. However, with the ongoing modernization of society, the increasing importance ascribed to individualism and the decreasing influence of religion, loneliness has become rampant [1].

Frieda Fromm-Reichmann (1959) [2] was the first to consider loneliness to be a psychiatric condition and acknowledge the challenge in conceptualizing the term. He wrote that *"The writer who wishes to elaborate on the problems of loneliness is faced with a serious terminological handicap. Loneliness seems to be a painful, frightening experience that people will do practically everything to avoid. This avoidance seems to include a strange reluctance on the part of the psychiatrist to seek scientific clarification of the subject … Thus, loneliness is one of the least conceptualized psychological phenomena"* [3]. When Frieda Fromm-Reichmann used the term loneliness in the context of psychiatry, a broad range of experiences, i.e., social isolation and solitude, could not be distinguished from loneliness. Over the years, many researchers have distinguished loneliness from social isolation and solitude [3]. Accordingly, various attempts have been made to define the term: Perlman & Peplau (1982) defined loneliness as an "*unpleasant experience that occurs when a person's network of social relationships is deficient in some important way, either quantitatively or qualitatively"* [4]. De Jong Gierveld, who also designed a scale for the assessment of loneliness, defined it as a *"situation experienced by the individual as one where there is an unpleasant or inadmissible lack of (quality of) certain relationships* [5]." The Hidden Citizens report defines loneliness as *"a negative experience that involves painful feelings of not belonging and disconnectedness from others. It occurs when there is a discrepancy between the quantity and quality of social relationships we want and those we have. Thus, loneliness is a subjective psychological perception* [6]."

In a review of the literature, Heinrich & Gullone (2006) concluded that there are multiple definitions of the concept of loneliness that differ according to their their focus, i.e., definitions with a clinical focus, based on empirical psychological research and the definitions linking loneliness with social relationships and the human need to belong. In terms of factors contributing to developing and maintaining loneliness, Heinrich & Gullone (2006) identified different theoretical perspectives in this regard. These include the social need approach (which is influenced by early life experiences), cognitive discrepancy approach (which considers loneliness to be an outcome of faulty cognitive processes,

wishes, and perception), interactionist approach (i.e., character traits interact with situational and cultural factors), deficits in social relationships (i.e., the need to belong), and, finally, a consequence of the universal human need to belong [3, 7]. When one attempts to understand these various definitions in a more holistic manner, it can be said that loneliness can be understood in terms of social relationships, and that when a person's need for social relationships is not met, loneliness ensues.

In terms of various dimensions, researchers have again tried to understand loneliness as a transient (occasional short-lasting feelings of loneliness, encountered from time to time by the majority of people in their day-to-day lives), versus situational (the feelings of loneliness when faced by specific life crises/transitions that adversely affect the relationships in a person who has otherwise had satisfying relationships in the past), versus chronic loneliness (which is understood to be enduring feelings of loneliness and dissatisfaction with social relationships lasting for more than two years) [7]. Other researchers have also tried to distinguish loneliness as a state (current and immediate feelings of loneliness) versus a trait (enduring feelings of loneliness) [7]. The conceptualization of loneliness also differs with regard to whether it is a unidimensional or a multidimensional (three ways in which loneliness can manifest itself, i.e., intimate, relational, and collective) concept. Researchers have also tried to conceptualize it based on a medical model (cause, effect, and management) versus a typical experience (transient experience) [7]. Another conceptualization of loneliness includes collection versus social versus intimate dimensions. This conceptualization is based on the understanding of 'attentional space', as described by Hall (1963, 1966) [8, 9]. Hall categorized attentional space as either *intimate space* (an individual's most closely surrounding space), *social space* (a space where a person can comfortably interact with their nearest and dearest ones, i.e., friends, family and acquaintances), or *public space* (a more anonymous space) [8, 9]. Accordingly, intimate loneliness is experienced when a person someone very close to them, either due to death or a breakup in their relationship, and which can be understood to be *"the perceived absence of a person on whom one can rely on for emotional support at the time of crisis, a person who can provide mutual assistance, and who affirms one's value as a person"* [3, 10]. Social or relational loneliness arises due to the absence of perceived connections with the 'sympathy group', which usually comprises family members and close friends, who are understood to represent 'core social partners' and are prepared to support the person during times of need. Collective loneliness includes a lack of connections with people who are part of a network, i.e., people with whom one can connect due to nationality, political affiliation, etc. The collective network is usually the outermost social layer, with whom ties are not very strong but who can provide information and low-cost support [3]. Another conceptualization of loneliness includes emotional versus social loneliness. Emotional loneliness is understood to be an outcome of a lack of a close, intimate attachment to another person. In contrast, social loneliness is understood to be an outcome of a lack of a network of social relationships in which a person is a member of a group of friends sharing common interests and activities [11].

To summarize, it can be said that loneliness has been variously defined by different authors and understood to be a multidimensional negative subjective experience characterized by qualitative, rather than quantitative, lack of satisfaction with one's relationships or perceived social acceptance. There is a need to reach to a consensus definition, and future definitions should also include things like material positions when defining loneliness.

Various authors have also attempted to describe the different stages of the development of loneliness. Rokach [12], in the context of psychotherapy, described six stages of development of loneliness: pain and awareness, denial, alarm and realization, search for causes and self-doubt, acceptance, and coping with the loneliness. It was further elaborated that sufferers' recognition and appreciation of the fact that they are lonely depends upon the particular stage they are in.

THE DISTINCTION OF LONELINESS FROM SOLITUDE, SOCIAL ISOLATION, AND DEPRESSION

It is crucial to distinguish loneliness from other related phenomena in clinical practice (Table 1). In contrast to loneliness, solitude is a positive experience in which a person chooses to be with self and avoids people [13]. In contrast to loneliness, social isolation is understood to be a harmful physical state in which a person lacks social contact, and arises as a result of loss of mobility (due to illness or disability, unemployment, or health issues). The socially isolated person has a small network

Table 1. Distinguishing features of loneliness, solitude, social isolation, and depression

Characteristics	Loneliness	Solitude	Social Isolation	Depression
Mental/ Physical State	A negative state of mind	A positive state of mind	A negative physical state	Negative mood state, along with somatic symptoms
Crowd	One can feel lonely even among a crowd, and emotionally connecting with people can alleviate loneliness	One needs to be physically isolated from others to feel solitude	Lack of contact with other people or having few or no people with whom to interact	May or may not have contacts, just connecting with people may not help to bring all patients out of depression
Subjective/ Objective	Subjective		Objective	Both subjective and objective signs and symptoms
Company	Being without company	Prefer to be without company		
Reasons	Lack of satisfaction with relationships	Self-determined	Loss of mobility — due to illness or disabilities, unemployment, or health issues	Stressors, life events. Loneliness can lead to depression
Emotional state or distress	Sad due to being alone	Peaceful and pleasant	Sadness, restlessness, loneliness	
Consequences	Producing feelings of bleakness or desolation	Inner peace and quietness		

of kin and non-kin relationships [14, 15]. Loneliness also differs from depression, which is understood to be a negative mood state, along with somatic symptoms.

EPIDEMIOLOGY OF LONELINESS

Many studies have evaluated the prevalence of loneliness among the elderly. A recent systematic *review and meta-analysis, which evaluated the data of* loneliness amongst the elderly residing in residential and nursing care homes concluded that there is wide variation in its prevalence across different studies. The prevalence of moderate loneliness ranged from 31 to 100% with a mean of 61%, and that of severe loneliness ranged from 9 to 81%, with a mean prevalence of 35% among the elderly residing in residential and nursing care homes [16]. The review also suggested a lack of any significant difference in the prevalence of loneliness between males and females, although there is some data to suggest that females are more likely to admit to being lonely than males [16]. Another systematic review and metanalysis, which included data from 39 studies from high-income countries involving 1,20,000 older adults from 29 countries, reported a pooled prevalence of 28.5% (95%CI: 23.9%–33.2%). In terms of severity of loneliness, the pooled prevalence for moderate loneliness was 25.9% (95%CI: 21.6%–30.3%), and that for severe loneliness was 7.9% (95%CI: 4.8%–11.6%). The authors did not find any increase in the prevalence of loneliness with increasing age [17]; other data, however, suggest that there is such an increase [18, 19]. Recent evidence also suggests that there has been an increase in prevalence of loneliness during the ongoing COVID-19 pandemic [20].

FACTORS ASSOCIATED WITH LONELINESS AMONG THE ELDERLY

The perception that other people have rejected them and having disappointing relationships have been reported to be associated with the development of loneliness. Different systematic reviews suggest the association of loneliness with age (U-shape relationship), the female sex, poor quality of social contacts, low competence, socio-economic status, and chronic medical illnesses [21]. In terms of risk factors, some authors fail to distinguish the factors associated with loneliness and social isolation and have associated these with the death of a spouse, significant others, or friend. Other factors that have been linked to the development of loneliness and social isolation include loss of family involvement, loss of neighborhood network due to various reasons, retirement, loss of ability to drive due to physical or cognitive changes, extreme weather situations reducing mobility, sensory deprivation, and increased frailty [15]. Available data also suggest a higher prevalence of loneliness among the elderly experiencing 'empty nest' syndrome [22].

The authors of a study that evaluated the influence of environmental resources, health, and psychological factors on loneliness and depression concluded that psychosocial factors/barriers have the maximum impact on the etiology of loneliness [23].

CONSEQUENCES OF LONELINESS

Loneliness can lead to significant detrimental mental and physical health conditions and health outcomes. Loneliness is associated with a higher risk of cardiovascular diseases, stroke, diabetes mellitus, arthritis, depression, anxiety, and dementia. It has also been linked to increased cholesterol levels, platelet aggregation, poor immunological functioning, autonomic instability, low physical activity, malnutrition, insomnia, increased smoking, and alcohol use. It has also been linked to increased suicide rates, higher risk of mortality, health care costs, poor quality of life, and elder abuse [15, 24–26]. One study equated the adverse impact of loneliness to being the equivalent of smoking 15 cigarettes a day [15]. Emerging data also shows an association between loneliness with regular internet use and problematic internet use [27, 28].

ASSESSMENT OF LONELINESS

Different instruments have been designed to assess loneliness (Table 2) [15]. The available questionnaires vary from a single-item questionnaire to a 20-item questionnaire. These scales also differ in terms of being unidimensional or two-dimensional, with the De Jong Gierveld Loneliness Scale assessing both social and emotional loneliness. Clinicians choose the scale according to the feasibility of administering these scales to the elderly in their working conditions [15].

MANAGEMENT

Many interventions (Table 3) have been evaluated to address loneliness among the elderly [15]. The suggested interventions range from one-on-one, group therapy, and community interventions [10].

Table 2. Scales for assessment of loneliness [15]

Scales	Number of items	Remarks
Campaign to End Loneliness Measurement Tool	3	• Positively worded scale • Do not use the word loneliness • Three items – I am content with my friendships and relationships – I have enough people I feel comfortable asking for help at any time – My relationships are as satisfying as I would want them to be
De Jong Gierveld Loneliness Scale [5,29]	11	• Evaluates two types of loneliness, i.e., social (five items) and emotional (six items) loneliness • It can be used both in face-to-face interviews or as a self-administered questionnaire • It consists of positively (five items) and negatively (six items) specified items • High internal consistency — alpha coefficients ranging from 0.8 to over 0.9
De Jong Gierveld Loneliness Scale (De Jong & Tilburg, 2006) [5,29]	6	• Evaluates two types of loneliness, i.e., social (three items) and emotional (three items) loneliness
Revised University of California Los Angeles Loneliness Scale (UCLA-LS) (Russell et al., 1980, 1996) [30,31]	20	• Half of the items are positively worded and half are negatively worded • Avoids the use of the word loneliness in any of the items • High internal consistency, with an alpha coefficient of greater than 0.9
Three-item University of California Los Angeles Loneliness Scale (UCLA-LS) (Hughes et al., 2004) [32]	3	**Items** • How often do you feel that you lack companionship? • How often do you feel left out? • How often do you feel isolated from others?
Four-item University of California Los Angeles Loneliness Scale (UCLA-LS)		**Items** • How often do you feel that you are “in tune” with the people around you? • How often do you feel that no one really knows you well? • How often do you feel you can find companionship when you want it? • How often do you feel that people are around you but not with you?
Single-Item Questions (The direct measure of loneliness) (Office for National Statistics, United Kingdom) [33]	1	• How often do you feel lonely?

Table 3. Suggested interventions for loneliness

- **Improving social skills:** speaking on the phone, giving and receiving compliments, enhancing non-verbal communication skills
- **Enhancing social support:** mentoring programs, buddy-care program, conference calls
- **Increasing opportunities for social contacts:** social recreation intervention
- **Addressing maladaptive social cognition:** cognitive behavioral therapy
- **Psychological interventions:** mindfulness interventions, reminiscence therapy, laughter therapy, Tai Chi Qigong meditation
- **Animal interventions**
- **Befriending interventions**
- **Leisure/skill development intervention:** exercises, computer training, video gaming, gardening, general activities
- **Social facilitation:** videoconference program, group meetings/discussions

Different authors have categorized these interventions differently; some that are suggested to benefit persons experiencing loneliness include improving social skills, enhancing social support, increasing opportunities for social contacts, and addressing maladaptive social cognition [34]. In a systematic review of such studies, the authors reported that addressing maladaptive social cognition was the most effective intervention for loneliness [34].

Further, it is suggested that one-on-one interventions be better than group interventions [34]. A recent literature review also supports the beneficial role of psychological interventions targeting maladaptive social cognition [35]. Cognitive behavior therapy involves educating individuals to recognize their automatic negative thoughts about others and their social interactions and consider these thoughts to be possibly faulty hypotheses that require verification, rather than considering them to be facts and acting on the same. Accordingly, the maladaptive social perceptions and cognitions are challenged to reduce loneliness [34, 36].

In terms of pharmacological interventions, there are none such that have been shown to be useful. Data from animal studies suggest that antidepressants like selective serotonin reuptake inhibitors (SSRIs), neurosteroids, and oxytocin may help to reduce loneliness to some extent [10].

CONCLUSION

Loneliness is highly prevalent among the elderly in today's world. It is suggested that the prevalence of loneliness has been increasing over the years. It is also recognized that loneliness is associated with significant adverse mental and physical health outcomes. Hence, there is an urgent need to increase awareness about the psychological construct of loneliness and carry out interventions to reduce its adverse health outcomes. Many assessment instruments are available to assess loneliness among the elderly. Although many interventions have been evaluated in terms of their ability to mitigate loneliness, addressing maladaptive social cognition appears to be an essential strategy to manage it.

Article history:
Submitted: 19.01.2022
Accepted: 07.02.2022
Published: 31.03.2022

Funding: The article was written without external funding.

Conflict of interests: The author declares no conflict of interest.

For citation:
Grover S. Loneliness among the elderly: a mini review. Consortium Psychiatricum 2022;3(1):30–36. doi: 10.17816/CP143

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