Will the pandemic reframe loneliness and social isolation?

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Public health and social measures introduced during the COVID-19 pandemic have brought profound changes to everyday life, exacerbating pre-existing concerns of increasing levels of loneliness and social isolation. Evidence is still evolving about the groups most affected by loneliness and social isolation and the manner in which they are affected. A timely article by Katie Davies and colleagues[1] in *The Lancet Healthy Longevity* uses nationally representative data for community-dwelling adults aged 50 years and older from the English Longitudinal Study of Ageing over 14 years to show that loneliness and social isolation are much more complex and have greater importance for health and wellbeing than is often perceived. For many years, loneliness and social isolation were seen as a social problem among primarily older people and as a natural part of growing older. More recently, they have been framed as a public health issue that can affect people of any age.[2] Tension often exists between those who perceive a medicalisation of loneliness and social isolation and those who feel that their impact on health and mortality is of insufficient concern to health professionals and indeed, society as a whole. How loneliness and social isolation are defined, measured, studied, and more importantly, addressed is key to advancing this area of work.[3]

Davies and colleagues[1] highlight that there is much more to understand about the separate (although sometimes overlapping) issues of loneliness and social isolation, especially when considering the relationship between subjective and objective experiences and early intervention. The authors' focus on frailty and its relationship with loneliness and social isolation is fitting, given the dearth of work in this area. Rates of frailty increase with age, and the syndrome is progressive, leading to functional decline. However, early detection of frailty can help to prevent, or at least potentially slow the decline and thereby improve quality of life.[4] As is the case with loneliness and social isolation, how frailty is defined and measured is key, whether as an accumulation of deficits[5] or as a decreased reserve resulting from cumulative declines.[6] By using frailty as the health outcome of loneliness and social isolation, Davies and colleagues underscore the association of both with poor physical health outcomes. Moving beyond the view that frailty is associated with loneliness and social isolation, the authors argue that both loneliness and social isolation could increase the risk of developing frailty.

Loneliness and social isolation are often influenced by our social context, and the authors might have gone further into accounting for the social and economic circumstances that influence health generally, and frailty specifically. It is important to understand the mechanisms and factors that might play a mediating or moderating role. Loneliness, social isolation, and indeed frailty are not static, and although some individual characteristics (eg, age and ethnicity) are often included in research, there is less focus on the role of the built environment and structural factors such as poverty. The dearth of longitudinal qualitative studies on loneliness and social isolation needs to be addressed to help understand the pathways into and out of loneliness and social isolation; for example, how personality, social circumstances, and life events determine loneliness, or the effect of technological changes on social networks and thereby social isolation.

Public health provides a useful framework to assess the causes and consequences of loneliness and social isolation, as well as interventions that could be helpful. Greater emphasis is therefore required on a public health approach of primary prevention and on population-based strategies in order to promote social health and recognise the role of life course, living conditions, communities, socioeconomic factors, and broader ecological factors.[2] Using a public health framework and population-level approach for prevention could help to combat loneliness by designing social infrastructures and social institutions that help facilitate connections and build social cohesion within communities.[7] In addressing the causes and consequences of loneliness and social isolation, research must be guided by robust evidence. Unfortunately, too often there is little connection between research evidence and intervention design, and too often the evidence is weak.[8] The very personal nature of loneliness means that tailored interventions are needed to meet individual requirements.[9] Furthermore, social distancing restrictions during the COVID-19 pandemic have rendered many of the commonly used loneliness and social isolation interventions impractical. Nursing home residents, for

example, have been particularly affected by the pandemic, both in terms of elevated risk of infection due to the presence of frailty and multimorbidity, as well as the restrictions on visitations aimed at reducing transmission. A cross-sectional survey[10] found that 6–10 weeks after the introduction of a visitor ban in the Netherlands, high levels of loneliness and depression in residents were reported, as well as exacerbations in mood and behavioural problems, based on retrospective reports by relatives and staff.

The pandemic has meant that many more people have gained personal insight into what it means to be socially isolated, lonely, or both. In addition to changing the nature of social connections, the pandemic has also potentially changed perceptions of loneliness and social isolation, and challenged the stereotypical view of the lonely or isolated. There is now a potential opportunity to build on the greater empathy, compassion, caring, and concern that have been shown towards those experiencing loneliness and social isolation, and to set in place policies and structures to address root causes and to support healthy choices.

Although governments have correctly focused on reducing transmission rates of infection, there is also an imperative to address the wider social impact of COVID-19. In particular, we need to understand what support is needed now, and what support organisations, services, and communities can provide to plan beyond this stage of the pandemic. Davies and colleagues' work reinforces the important message that loneliness and social isolation are associated with poor health outcomes. Governments across the world will increasingly need to focus on both the short-term and long-term implications of loneliness and social isolation as public health priorities and recognise that they are not just issues facing individuals but society as a whole.

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