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Invited Perspective

Timely Insights Into the Treatment of Social Disconnection in Lonely, Homebound Older Adults

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Social relationships are essential to human health and well-being across the life span. This fundamental need has suddenly become more explicit as societies impose "physical distancing" regulations in response to the COVID-19 pandemic. In this issue, Choi et al. provide timely and much needed insights into the treatment of social disconnection in lonely, homebound older adults.[1]

Social isolation (having few social ties or contacts) and loneliness (the subjective experience of being alone) are two distinct and reliably measured constructs that are often conflated. Loneliness is a feeling of deprivation and distress that is only weakly correlated with objectively measured social isolation. Loneliness arises when there is a mismatch between desired and available forms of social and emotional connection. Thus, it is possible to be isolated but not lonely or lonely but not isolated. Therein lies the opportunity to ameliorate or reduce feelings of loneliness, and possibly its health implications, even in the context of limited social contact or physical separation from others.

Social isolation and loneliness are both important modifiable factors impacting mental and physical health in older adults. For example, in meta-analyses, social isolation and loneliness were associated with a 50% increased risk of developing dementia,[2] an approximately 30% increased risk of incident coronary artery disease or stroke,[3] and a 26% increased risk of all-cause mortality.[4] Of special concern to the geriatric psychiatry community are the mental health implications for older adults. These markers of social disconnection increase the likelihood of developing or worsening late life depression and anxiety and, reciprocally, these psychiatric conditions also predispose to social disconnection.[5,6]

Though late adulthood is often a period of social-emotional well-being, it also poses an increasing risk of loneliness in the setting of age-related factors such as the loss of close relationships and the contraction

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of social networks, sensory impairments (especially hearing loss), chronic health conditions, mobility limitations, and other physical and cognitive declines. A nationally representative German study of over 16,000 adolescents and adults found the lowest prevalence of loneliness among individuals in the sixth to seventh decades of life, yet striking elevations in loneliness among those in the eighth decade and beyond.[7] For these reasons, effective interventions for social disconnection, especially loneliness, are much needed for older people.

There have been few randomized controlled trials of interventions for loneliness and social isolation interventions in older adults. A recent review and synthesis of the literature recommended that future interventions should (1) specifically target socially isolated and/or lonely individuals, (2) have a sound theoretical basis, (3) utilize established therapeutic approaches with trained facilitators and (4) involve active participation of the older adult.[8] Other reviews have further suggested that interventions that address maladaptive thinking or educate regarding maintenance and enhancement of social networks may be most effective and that technology may play a useful role in these interventions.[9,10]

In the current study, Choi et al. check all of the above boxes. This well-designed protocol examined the effect of a tele-delivered behavioral activation (Tele-BA) intervention on social isolation and loneliness measures compared to a tele-delivered friendly visit (Tele-FV) intervention, for homebound lonely older adults in Texas and New Hampshire. For the Tele-BA protocol, lay coaches provided psychoeducation regarding social connection, helped participants identify and engage in values-based, rewarding social activities and worked with participants to address barriers to social connectedness. The Tele-FV intervention used supportive techniques such as adding perspective and facilitating self-expression but did not include coaching or skill development.

The three main outcomes were social interaction, loneliness, and perceived social support measured at baseline, at the completion of the 5-week interventions (week 6) and 6 weeks later (week 12). The authors report that compared to the Tele-FV intervention, the Tele-BA intervention was associated with greater increase in social interaction, greater satisfaction with social support, and decrease in loneliness. Benefits were sustained at 12 weeks. There were also improvements in secondary outcome measures of depression and disability (probing cognition, mobility, self-care, and life activities) in the Tele-BA group compared to the Tele-FV group. Notably, declines in depression were observed at 12 but not 5 weeks for the Tele-BA group, suggesting enhanced effects over time.

There are many strengths to this study. The participants were initially identified and referred to the investigators through home-delivered meals programs and thus represent a face valid sample for studying social isolation and loneliness. It is a strength that it was carried out in two geographically and culturally distinct study sites. The sample was well-characterized and defined as cognitively intact, nondepressed or mildly depressed, and nonsubstance abusing, which minimized important confounding or complicating factors. The prespecified primary outcomes were well chosen as they survey three core constructs encompassed within the broader "social connection" term. The secondary outcomes (depression, disability) are also key clinical constructs associated with low social connectedness. The interventions were brief, efficiently delivered, and potentially scalable. The effect sizes of the Tele-BA intervention compared to the Tele-FV intervention were striking, particularly for the loneliness outcome.

Is this research finding relevant to social isolation and loneliness in the context of COVID-19? The central finding of this study is the somewhat surprising potency of brief, remote, lay coach-delivered, behavioral activation techniques for mitigating loneliness. Qualitative research suggests that personal characteristics such as acceptance, compassion, and companionship seeking behavior are likely to help prevent or overcome loneliness in older adults.[11] In a recently published, randomized controlled trial involving younger adults, investigators found that a 2-week smartphone mindfulness and acceptance training application significantly reduced loneliness and increased social interactions.[12] Studies such as these provide well-founded hope that therapeutic techniques can be effectively leveraged and delivered for the social-emotional health of populations worldwide during this historic pandemic and time of social disruption.

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