

### “Social Distancing” Amid a Crisis in Social Isolation and Loneliness

*To the Editor:* The coronavirus disease 2019 (COVID-19) pandemic and social distancing are transforming the way we interact. Before the pandemic, national studies reported 1 in 4 older adults were socially isolated and more than 40% experienced loneliness. Decades of observational studies have demonstrated the long-term negative health outcomes of social isolation and loneliness.<sup>1,2</sup> The COVID-19 crisis has exacerbated these challenges, with worsening social isolation and loneliness among those who live alone or are frail and even declines in the well-being of older adults with previously active or healthy social lives. Community centers for older adults have closed, nursing homes have terminated visitation, and grandparents are unable to visit their grandchildren. Initial hopes that such restrictions would be temporary are now giving way to a need to prepare for managing the unintended consequences of prolonged social distancing and the associated impact on the health and well-being of older adults. We present an approach to identify older adults most at risk during prolonged distancing and suggest strategies that could ameliorate the effects of sustained social distancing.

#### IDENTIFYING OLDER ADULTS AT RISK

Although the term *social distancing* has been widely used during the COVID-19 pandemic to describe keeping space between ourselves and others outside of our homes, public health recommendations have increasingly shifted to using the term *physical distancing*. Regardless of terminology, the impact on well-being among older adults is variable due to differing abilities to maintain social connections while physical distancing. Individuals who are homebound, depressed, or cognitively impaired may struggle to adapt to physical distancing because of reliance on in-person care and interaction. In contrast, many older adults may successfully adjust to this new reality with support from community organizations, friends, family, and/or neighbors. Clinicians should monitor whether or not these support systems are sustained. This is certainly *not* the time to overhaul clinical measures or deploy lengthy surveys. However, we suggest assessing a few focused measures of social connections in addition to common geriatric assessments to identify individuals at risk who may have increasing difficulty finding help with activities of daily living or instrumental activities of daily living, or even maintaining essential needs (ie, food,

water, and shelter). Each domain can be assessed through a single question.

First, older adults should be assessed for loneliness. Contrary to common practice, it is best *not* to ask the direct question “Do you feel lonely?” due to concerns for underreporting and stigma with self-identifying as lonely.<sup>3</sup> Instead, individuals should be asked if they feel isolated, they lack companionship, or feel left out, as is done in several loneliness questionnaires. These responses represent an overall indicator of whether social connections are adequate and may predict risks of future psychological distress. Loneliness is frequently unrecognized because it can occur even when older adults are married or surrounded by friends or family.

Second, individuals should be assessed for their perceptions of social support by asking, “How many people do you feel you can depend on or feel close to?” Prior research suggests that the perception of social support can reduce stress.<sup>4</sup> This may be particularly important during the COVID-19 pandemic to reduce feelings of worry, anxiety, or stress. Notably, only having one person to rely on may be a red flag for increased caregiver burden in the context of prolonged physical distancing.

Third, older adults should be assessed for their access to phone or video communication technologies. Notably, access to communication can be augmented by living with individuals who can support their technology use or compensate for vision or hearing impairment to help them communicate with social contacts or healthcare providers. Individuals who feel lonely, perceive low resources for social support, and cannot use alternatives to in-person communication are at increased risk during prolonged physical distancing. Exceptions to physical distancing may exist for high-risk older adults. Geriatricians and families should develop or utilize decision tools to help balance the risk and benefits of physical distancing. Current challenges are increasing our reliance on technology. For example, active and passive technologies (ie, alerts and sensors, respectively) offer unique opportunities. However, many of these solutions need further evaluation and are not available, accessible, or acceptable to many older adults and their families.<sup>5</sup>

#### CLINICAL AND PUBLIC HEALTH STRATEGIES

Addressing unmet social needs requires feasible strategies that occur at the person and population level.<sup>6</sup> Health systems are increasingly engaging in efforts to address social needs. Telemedicine can provide a safe platform to assess salient geriatric issues (ie, safety, mobility, mood, medications, appetite, or bowel function) or COVID-19 symptoms and provide an avenue for counseling or discussion. Moreover, it can increase access to mental health resources for

DOI: 10.1111/jgs.16527


the lonely or those anxious about the uncertainty related to the duration of home confinement. However, clinicians should recognize that even among older adults capable of using this technology, this communication medium may be insufficient to meet the social needs of this population for prolonged periods. We therefore suggest clinicians take the lead on designating individuals who can visit older adults while balancing the risk of COVID-19 exposure and need for social support. Designated individuals might be people who are tested more frequently (assuming testing becomes more widespread) or who have been verified for appropriate use of personal protective equipment). In addition, connecting older adults with community resources (eg, Meals on Wheels) that have implemented precautions to mitigate viral transmission or that already existed virtually (eg, Friendship Line, Virtual Senior Center) can address certain needs.

At the population level, strategies to address social isolation and loneliness is largely underfunded and understudied.<sup>1</sup> We unfortunately cannot wait for evidence-based interventions to emerge as this crisis unfolds. However, we can learn from prior natural disasters including the Chicago heat wave of 1995 that took the lives of 465 primarily older mobility-impaired, socially isolated individuals in 1 week.<sup>7</sup> Based on this event and existing research, we know strategies should increase awareness about social isolation and loneliness, harness enthusiasm for volunteerism, utilize health record data to target those in need, and support organizations that are meeting the needs of older adults while adapting to physical distancing.


Various technologies to address social isolation and loneliness have been tested, although the evidence to support these interventions is largely “inconsistent and weak.”<sup>1,8</sup> There is hope. A recently published randomized controlled trial of a video-conferenced behavioral activation intervention facilitated by a lay coach was able to increase social interactions and decrease loneliness among homebound older adults.<sup>9</sup> We now have a unique opportunity to develop methods for check-ins by neighbors or to adapt programs akin to the Jersey, British Channel Islands, “Call & Check Visits,” where postal workers support older adults on their delivery routes. A knock on the door or hello from a distance from a postal worker may provide an opportunity to monitor and support older adults in the community. In addition, advocating initiatives that promote community cohesion (ie, yard, porch, and balcony or terrace gatherings) could also be beneficial in that it may provide an opportunity for neighbors to monitor the well-being and functional status of older adults from a distance. Efforts akin to the UK “Campaign to End Loneliness” and AARP “Connect2Affect” are also important and can increase awareness and offer resources to support older adults during crisis. Striving for patient-centered solutions that effectively consider benefit and burden can potentially create connections that are sustained even after this crisis. Lastly, providers and policymakers should revisit the Federal Emergency Management Agency’s “Whole Community Approach” and find ways for municipal leaders to exchange strategies and align needs with resources.

The COVID-19 pandemic is a timely reminder of how social well-being has a powerful impact on health.

Identifying older adults at risk for the immediate and unintended health consequences of physical distancing is critical. Comprehensive geriatric and social needs assessments should be a part of the medical record so that practices, health systems, and communities may seamlessly mobilize support for those in need when public health crises occur. Technology undeniably offers novel opportunities as well as nuanced challenges; it should not limit our imagination or constrain how we balance the risk and benefit of in-person interactions. Physicians and health systems in conjunction with public health and policymakers can be positioned to identify and address social needs, optimize health, and flatten the curve of this extraordinary pandemic. Addressing social isolation and loneliness under normal circumstances is challenging; nevertheless, the current constraints of physical distancing offer a unique opportunity to envision, pilot, or implement novel solutions that could have a lasting impact on the health and well-being of older adults.

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## ACKNOWLEDGMENTS

We are sincerely appreciative of Cynthia M. Boyd, MD, MPH, and Thomas E. Finucane, MD, for their critical review and insightful comments.

**Financial Disclosure:** Thomas K.M. Cudjoe was supported by National Institute on Aging (NIA) Grants for Early Medical/Surgical Specialists’ Transition to Aging Research (GEMSSTAR) (R03AG064253). Ashwin A. Kotwal was supported by an NIA GEMSSTAR grant (R03AG064323).

**Conflict of Interest:** The authors have declared no conflicts of interest for this article.

**Author Contributions:** *Manuscript concept and drafting:* Cudjoe and Kotwal. *Critical revision of manuscript for important intellectual content:* Cudjoe and Kotwal.

**Sponsor’s Role:** None.

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