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Strategies to Reduce Loneliness and Social Isolation among Elderly People - A Review

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"The greatest disease … is not TB or leprosy; it is being unwanted, unloved, and uncared for. We can cure physical diseases with medicine, but the only cure for loneliness, despair, and hopelessness is love."

- Mother Teresa

Abstract: ***Loneliness and social isolation have emerged as persistent public health concerns across the life course, with older adults experiencing heightened vulnerability due to biological, psychological, and social transitions. Loneliness reflects a subjective sense of disconnection, while social isolation refers to the objective absence of social relationships and interactions, both carrying serious health consequences. Evidence links these conditions to increased risks of cardiovascular disease, mental health disorders, cognitive decline, and premature mortality, with effects comparable to major lifestyle risk factors. Global and Indian data, including findings from the LASI Wave 1 survey, highlight the growing prevalence of loneliness and associated psychiatric conditions among ageing populations, particularly in specific regional contexts. The discussion outlines a multi-level framework of interventions spanning individual, community, and societal domains. Strategies such as cognitive behavioural therapy, social prescribing, digital engagement, community infrastructure development, and inclusive public policies are examined alongside empirical evidence from randomized trials, systematic reviews, and population studies. Together, these approaches underscore the need for coordinated, age-sensitive responses that address both emotional experiences and structural determinants of social connection in later life.***

Keywords: Loneliness, Social isolation, Older adults, Social connectedness, Public health strategies

1. Introduction

Loneliness and social isolation are the unavoidable manifestation reached over the ages. Old age is the most vulnerable to loneliness though it happens throughout the life cycle. Loneliness is the feeling of being alone or disconnected from others, or feeling like you don't have meaningful relationships or a sense of belonging. Social Isolation is the objectively having few social relationships, social roles, group memberships, and infrequent social interaction. Social Connectedness is the degree to which any individual or population might fall along the continuum of achieving social connection needs. Social Connection is a continuum of the size and diversity of one's social network and roles, the functions these relationships serve, and their positive or negative qualities. Loneliness is just not a bad feel. Loneliness harms individual and moreover societal health. Social isolation and loneliness are associated with a greater risk of cardiovascular disease, dementia, stroke, depression, anxiety, obesity, physical inactivity and premature death. The mortality impact of being socially disconnected is similar to that caused by smoking up to 15 cigarettes a day. Old age faces these all consequences silently. So it is high time to rule out the strategies under the open umbrella of solutions.

Scenario:

According to the World Health Organization (WHO), 34% of people experience loneliness among which 21% is episodic and 13% is chronic loneliness. A global survey in 2021 found that 33% of adults worldwide experience loneliness, with 50% of respondents in Brazil reporting feeling lonely often, always, or sometimes. A Meta-Gallup survey found that 24% of people age 15 and older self-reported the feeling of very or fairly lonely. Up to 1 in 3 older people feel loneliness in various countries and regions of China, Europe, USA, Latin America.

Loneliness and social isolation is alike an epidemic now. This serious public health concern is not absent in Indian society also.

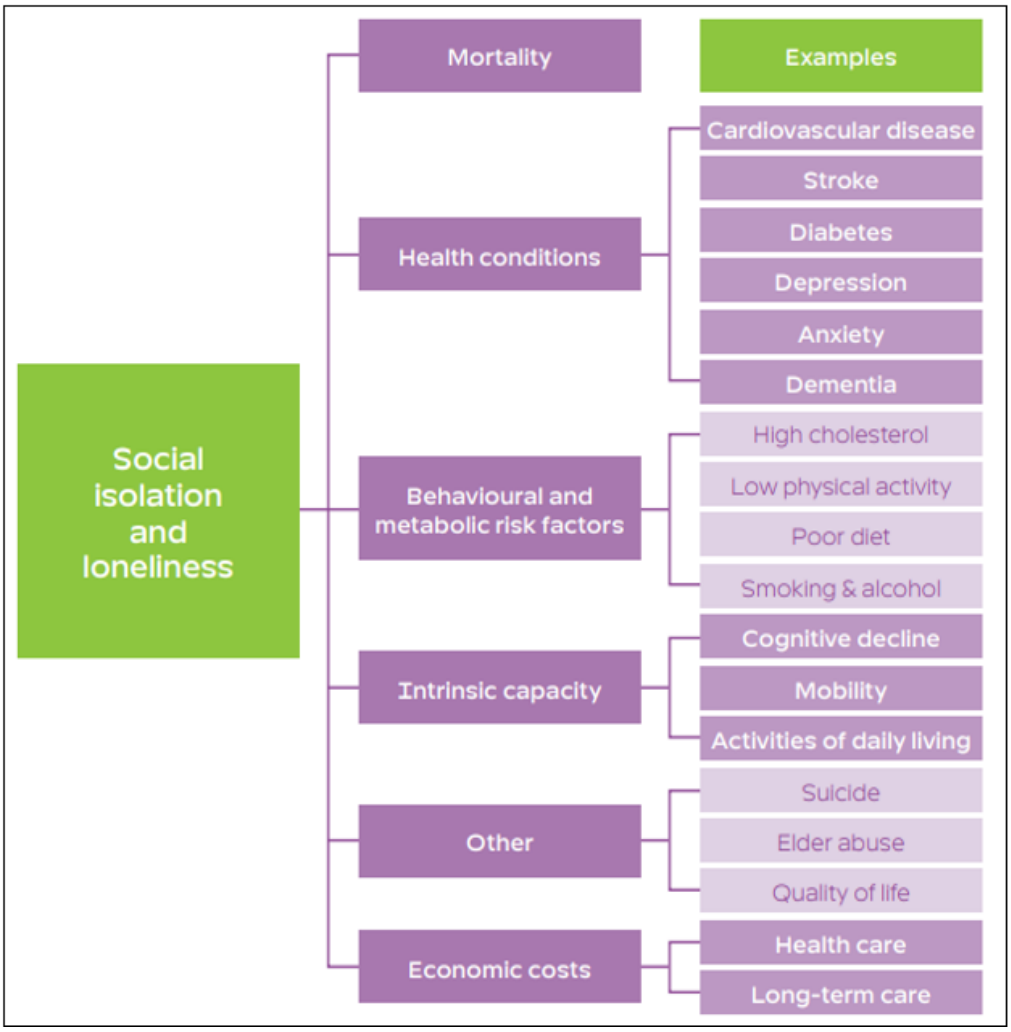
Table 1: The LASI wave-1 survey (2017-18) in India

Individual-Level Key Indicators	Age		Sex		Residence		Total years
	45-59 years	60 years & above	Male	Female	Rural	Urban	
Depression (%)	0.5	0.8	0.5	0.7	0.7	0.5	0.6
Psychiatric problems (%)	0.4	0.4	0.5	0.3	0.3	0.5	0.4

Table 2: The LASI wave-1 survey (2017-18) in West Bengal

Individual-Level Key Indicators	Age		Sex		Residence		Total years
	45-59 years	60 years & above	Male	Female	Rural	Urban	
Depression (%)	0.69	3.4	1.5	2	2.2	1	1.8
Psychiatric problems (%)	0.79	1.1	1	0.85	0.87	0.99	0.91

Consequences of social isolation and loneliness



At the level of the individual, physical factors such as having heart disease, stroke or cancer can increase the risks of both social isolation and loneliness, although the relation is often bi-directional. Decreases in intrinsic capacity, such as sensory impairment and hearing loss, increase the risks, as do psychiatric disorders such as depression, anxiety and dementia. Certain personality traits- such as neuroticism (i.e. negative affect), disagreeableness and low levels of conscientiousness- increase the risk of loneliness, and these are partly genetically determined. The absence of supportive relationships and difficult or unfulfilling relationships can increase loneliness. Life transitions and disruptive life events such as retirement and bereavement can increase the risks of both social isolation and loneliness among older people. Social groups at greater risk of social isolation and loneliness, which are sometimes poorly served by mainstream services, include ethnic minorities; lesbian, gay, bisexual and trans+ people; people with physical and learning disabilities and long-term health conditions; care-givers; and older people in residential and nursing care. Being an immigrant is also a risk factor, as immigrants tend to have fewer - especially long-standing- social ties and less social integration and often face language and communication barriers. At community and societal levels, lacking socio-economic resources, limited education, inadequate transportation, lack of access to digital technology, poor housing, ageism, marginalization and remote residence can all lead to loneliness and social isolation.

Strategies: The strategies to address the loneliness are unique for individual. Till to generalize the connection of elderly people the strategies are differentiated in individual level, community level and societal level. All communities have its own trait to be connected in their pattern of living.

Identification of alone people is the foremost step of intervention. Old age counseling corners and outreach services are the stem to overcome barriers of ageism and related stigma.

1) Individual- and relationship-level interventions:

Interventions at this level are based on three main mechanisms:

a) Maintaining and improving people's relationships: Evidence suggests that open communication among the elderly and other family members can break the ice of relationships. Careful listening is the basic solution to numbers of problems faced by the old aged people. Family caregivers has to leverage the following ways -
- Remaining independent
- Having personal safety
- Continuing to participate in important activities
- Not being a burden on family and other loved ones
- Having a say in who is helping with what

Cognitive behavioral therapy has been most supportive. Smith R et al conducted a secondary analysis of a randomized controlled trial on effect of group cognitive behavioral therapy in a community sample of older adults to reduce loneliness. The study examined the change in loneliness in sixty-two older adults (≥60 yrs; 65% female) who took part in a previously reported randomized controlled trial for the treatment of co-morbid depression and anxiety. Older adults were randomized to a 12-week group CBT or waitlist control condition, and the intervention group was followed-up after three months. Results showed that Linear Mixed Model analyses indicated that after controlling baseline cognition, depression, and anxiety, participants who completed CBT experienced a significant decrease in loneliness while the control group did not. This reduction was maintained at follow-up.

Kall A et al investigated the efficacy of an 8-week internet-based treatment containing CBT components to reduce feelings of loneliness among Seventy-three participants randomly allocated to treatment or a wait-list control condition. The participants were assessed with standardized self-report measures of loneliness, depression, social anxiety, worry, and quality of life at pretreatment and post treatment. Robust linear regression analysis of all randomized participants showed significant treatment effects on the primary outcome measure of loneliness (between group Cohen's d = 0.77), and on secondary outcomes measuring quality of life and social anxiety relative to control at post assessment. The results suggested the potential utility of internet-based CBT in alleviating loneliness.

b) Supporting people to develop new relationships: Interventions for social isolation and loneliness among older people can be delivered either one-to-one or in groups and either digitally or face to face.

The supporting interventions include social skills training, psycho education (providing information and support to better understand and cope), peer-support and social activity groups, "befriending" services, to offer supportive relationships either in person or over the phone, usually by volunteers. Social prescribing helps elderly patients to access local non-clinical sources of support. The awareness can be increased by mindfulness training, psychopharmacology, including anti-depressants and coalitions and campaigns at the community level.

Shekelle P G et al conducted a systemic review and meta analysis searching total 5971 titles, 36 RCTs and 24 observational studies from the computerized databases using broad terms such as "loneliness" or "lonely" or "social isolation" or "social support" from Jan 1, 2011 to June 23, 2021. The evidence suggested that group-based treatment was associated with reduced loneliness (standardized mean difference for RCTs = − 0.27, 95% CI − 0.48, − 0.08). Five RCTs and 5 observational studies provided moderate certainty evidence that internet training was associated with reduced loneliness. Low certainty evidence suggested that group exercises may be associated with very small reductions in loneliness. Evidence was insufficient to reach conclusions about group-based activities, individual in-person interactions, internet-delivered interventions, and telephone-delivered interventions.

Tieskoetter L J conducted a descriptive cohort epidemiological study to assess loneliness pre-and post implementation of a mindfulness telephone line over three months among 22 older adults enrolled in a befriending socialization program was used by convenience sampling. The Iowa Model of Evidence-Based Practice framework was applied to guide the implementation of a practice change and evaluate its impact on healthcare outcomes. Results showed that the mindfulness was independent of post-implementation perceived loneliness (p= .697) and quality of life (p= .711). No difference was noted between the post-implementation mean loneliness scores among the mindfulness participation (M= 3.57, SD= 2.70) and no participation groups (M= 3.53, SD= 1.88), t (20)= -0.04, p= .970. Mindfulness participation did not have a significant difference for the mean loneliness scores in the pre- (M= 3.86, SD= 2.54) and post-implementation screenings (M= 3.57, SD= 2.70), t (6)= 0.79, p= .457.

c) Changing how people think and feel about their relationships: In relationship elderly people has thought or feeling to intervene digitally. Digital interventions are of particular the Internet, smart phones and social media – in mediating social relations. Digital interventions include training in use of the Internet and computers, support for video communication, messaging services, online discussion groups and forums, telephone befriending, social networking sites, chatbots and virtual artificial intelligence "companions". Although these gadgets are effective, the findings are often mixed or inconclusive. The extent to which online relations can supplement face-to-face interactions and the potential harmful effects of digital interventions, particularly the risk of further isolating older people, are currently poorly understood. This is important to protect the right to remain offline and develop alternatives for those who cannot or do not wish to connect digitally.

2) **Community-level strategies**: Several strategies at the community level have the potential to help reduce loneliness and social isolation. Some address the infrastructure – such as transportation, digital inclusion and the built environment – required to ensure that people can maintain their existing and form new relationships and to deliver interventions to reduce social isolation and loneliness.

Appropriate, accessible, affordable transportation is vital to keep people connected. Jopling k showed that transportation policy on social isolation and loneliness is limited, a study in the United Kingdom showed that the introduction of free bus travel for people aged 60 years and over reduced loneliness and depressive symptoms. The built environment in communities can either foster or hinder social connection. The design of housing in communal areas, of public spaces - good lighting, benches, public toilet and of restaurants, shops and cultural institutions such as libraries and museums - accessibility and inclusivity may affect social isolation and loneliness.

Kim K et al analyze data for 3027 adults aged 65 and older who reside in 262 zip code areas. Following AARP guidelines, the sample was allocated into two groups: an AFC group (livability score of 51+; n = 2364) and a non-Ageing Friendly Community (score ≤ 50, n = 663). The outcome variable was self-rated health (M = 3.5; SD = 1.1; range: 1–5) using an inverse probability weighting approach to evaluate whether older adults who live in an AFC reported better self-rated health than those who live in a non-AFC. Result showed that older adults who lived in an Ageing friendly community had better self-rated health than those in a non-AFC (b = 0.08, p = 0.027). Compared to non-Hispanic Whites, Black and Hispanic older adults reported worse self-rated health. Inasmuch as living in an AFC can promote the well-being of older adults, policymakers and practitioners should continue to develop and sustain high-quality, accessible built and social environments.

3) **Societal-level strategies**: Societal level strategies to reduce isolation and loneliness include laws and policies to address discrimination and marginalization, socioeconomic inequalities, digital divides, social cohesion and intergenerational solidarity. They may also seek to change social norms that prevent social connection, such as prioritizing accumulation of financial rather than social capital.

2. Conclusion

Loneliness and social isolation represent complex challenges that extend beyond individual experience and reflect broader social, environmental, and policy contexts. Older adults face distinct risks shaped by health conditions, life transitions, and reduced access to supportive networks, often compounded by ageism and structural barriers. Evidence reviewed across individual, community, and societal levels indicates that targeted psychological interventions, supportive social environments, accessible infrastructure, and inclusive policies can collectively reduce isolation and improve well-being. While several strategies show promise, their effectiveness varies by context, delivery mode, and population group. Continued evaluation in real-world settings remains essential to ensure that interventions are responsive, equitable, and sustainable, particularly within the broader goals of healthy ageing and social cohesion.

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