COMMENTARY

A New Pandemic of Loneliness

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Loneliness is the subjective feeling people experience when they feel less socially connected to others than they desire. Beyond the impact to mental health and well-being, loneliness is linked to detrimental health outcomes. During the COVID-19 pandemic, social distancing and isolation requirements likely exacerbated the prevalence of loneliness, which was reported by 1 in 5 American adults before the pandemic. Whether it be through in-person or virtual visits, primary care clinicians have tools and expertise to screen patients for loneliness, provide them supportive consultations, and refer persons with loneliness to helpful resources. As the societal changes from the pandemic continue to evolve, we recommend that primary care providers include loneliness screens as part of their standard workflow and consult with patients about effective interventions to reduce loneliness. (J Am Board Fam Med 2022;35:593–596.)

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The COVID-19 pandemic continues to be an experience of collective trauma,[1] marked for some by severe illness or death of loved ones, and evidenced by many with uncertainty, worry, and social isolation.[2] In the United States, 4 in 10 adults have reported symptoms of anxiety or depressive disorder during the pandemic, which is a significant increase from 1 in 10 US adults who reported these symptoms in the first half of 2019.[3] In addition to vaccination, efforts to slow the spread of the SARS-CoV-2, the virus causing COVID-19, have primarily consisted of improved hand hygiene, face coverings in public spaces, social distancing, and avoidance of crowded areas. Closure of social gathering spots, such as sporting events, places of worship, theaters, fitness centers, music venues, public museums, libraries, bars, and restaurants to reduce COVID-19 spread likely increased social isolation. Depending on individual risk profiles, people may have also chosen to limit family gatherings for holidays, weddings, graduations, and birthdays, ultimately increasing isolation from important others. Employment changes also significantly impacted social interactions, with millions of professionals shifting from in-person to predominantly remote work and many others experiencing unemployment due to business closures. With subsequent waves of infections as new virus variants emerge, it is unknown exactly when more normal social interactions may convene.

Recent research using cross-sectional online surveys has documented increases in perceived loneliness during the COVID-19 pandemic.[4,5] Data gathered during the lockdown period in March and April of 2020 determined the prevalence of loneliness in UK adults to be 27%.[4] For comparison, data collected from independent samples of US residents in April, May, and June through the Amazon Mechanical Turk (MTurk) platform showed loneliness increased significantly in American adults, with nearly 50% of those sampled in June exceeding the cutoff value for high loneliness even as restrictions were being relaxed.[5]

Loneliness is the subjective perception of social isolation, in which a person's actual social connections are less than they desire.[6] Loneliness has adverse consequences for mental and physical health,

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quality of life, and mortality,[7] equivalent to other well-known risk factors including cigarette smoking, sedentary lifestyle, obesity, and high blood pressure.[8] Most studies report a negative association between social isolation or loneliness and health status, primarily for depression and cardiovascular disease.[9] A recent meta-analysis determined the increased likelihood of premature mortality to be 29% for social isolation and 26% for loneliness, after controlling for multiple covariates.[8]

In addition to the impacts on physical health, loneliness can negatively impact emotional health, psychological functioning, and cognitive performance,[10] and quarantine-induced loneliness is associated with decreased psychological well-being and quality of life.[11] Previous research has shown that quarantine and isolation in the context of a public health emergency (eg, SARS outbreak, equine influenza) can increase psychological distress as well as rates of mental illness.[12–14] Stressors experienced during quarantine include fear of infection, sense of isolation, frustration, boredom, inadequate living supplies (eg, food, water, clothing, medical supplies), uncertainty, negative financial impacts, and stigmatization after quarantine.[12] Collectively, these stressors related to being quarantined predict negative psychological effects, namely post-traumatic stress symptoms, depressive symptoms, feelings of detachment from others, anxiety and related insomnia, and anger and irritability.[12] In an earlier study documenting the impact of quarantine for SARS in Canada, people experiencing quarantine reported increased incidence of PTSD (28.9%) and depressive symptoms (31.2%), with quarantine periods longer than 10 days being associated with greater symptoms.[13] Further, when loneliness is combined with poor psychological health, there is an increased risk for substance use disorders, including nonprescribed opioid use.[15]

Even before the COVID-19 pandemic and social distancing measures were enacted, the rate of loneliness among adults in the United States population was estimated to be approximately 20%.[16–18] Incidence of loneliness may be even higher in socioeconomically disadvantaged populations. For example, at our family medicine residency clinic which serves a predominantly underserved population (66% Black or African American, 20% White, 9% Asian; with 54% of the clinic population age 34 years or younger), 44% of our patients screened positive for loneliness before the pandemic.[19] Further, lonely patients had greater health care utilization, including longer hospital stays and more primary care visits and referrals in this study sample.[19]

Primary care clinicians can help mitigate health consequences of social isolation and loneliness by maintaining accessibility to comprehensive care and conducting routine screening. To stay connected with patients during the pandemic, many clinicians expanded health care delivery options to include telehealth (ie, telephone visits and videoconferencing) to ensure patients' needs were being met. Although most primary care clinicians did not offer telehealth services before the COVID-19 pandemic, many clinicians now note the benefits of telehealth for chronic disease management, preventative care, and care coordination, among others.[20] Telehealth services are likely to remain after the COVID-19 pandemic has subsided, and treatment of loneliness should consider the mode of health care delivery.

Whether during in-person visits or telehealth encounters, primary care clinicians provide continuity of care and emotional support to patients. As trusted health professionals for their patients, clinicians could routinely screen patients for loneliness in relatively brief and accurate ways.[21] For example, the UCLA Loneliness Scale is a 3-item measure of loneliness that has been widely utilized.[22] This tool was specifically designed to allow for quick screening of loneliness that could even be conducted over the telephone, which lends itself nicely to telehealth appointments as well as in-person visits. Nevertheless, a recent report suggests health care clinicians do not typically screen for loneliness, with most patients (87%) indicating they have not been asked about social isolation in health care settings.[23]

With brief tools such as the UCLA Loneliness Scale, primary care clinicians could easily change this trend and screen for loneliness during a patient's visit. Without adding substantial burden to clinic staff and providers, a loneliness screener could be completed by patients as they wait in the examination room, along with other brief mental health and social determinants of health screeners (eg, depression, food insecurity) that are gathered periodically. Researchers have identified individual risk factors that reinforce the necessity to screen certain populations, such as belonging to younger age-group, living alone, being separated

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or divorced, meeting clinical criteria for depression, having a chronic illness, experiencing poor quality sleep, and having insufficient emotional coping.[4,11,24] Of course, clinicians should use their clinical judgment and knowledge of patients' medical histories and life circumstances to determine who would be most urgent to screen for loneliness.

Addressing loneliness can have a positive impact on psychological, emotional, and physical health for patients of all ages. As a first step, clinicians can initiate a conversation with patients who screen positive for loneliness, assisting patients in identifying factors contributing to loneliness and educating them about ways to optimize their social connections, as social support is a protective factor for loneliness.[4] Depending on severity of symptoms, patients may be referred to behavioral health for therapy or to a community health worker or social worker for additional support. Even regular telephone calls with layperson volunteers have been shown to be effective in improving loneliness and depressive and anxiety symptoms for older adults during the pandemic.[25] Similarly, persons with limited resources or comfort with technology could engage in telephone conversations with close friends and family members to maintain social connection and support. Clinicians may recommend social prescribing, a non-medical intervention of community engagement, physical activity, arts appreciation, and volunteering. The goal of social prescribing is to help patients identify and ultimately use existing resources and structures in the community to improve well-being.[26] Although these remedies for loneliness often involve social interaction, which seem to counter guidance for infection control, clinicians can help patients navigate safe solutions by recommending patients get fully vaccinated against COVID-19, test for COVID-19 before and after social gatherings, and wear a mask in public settings or when socializing with persons who live outside their home. Developing social skills through therapy, strengthening social support networks, and increasing opportunities for social contact can help alleviate loneliness; however, challenging maladaptive social cognition is the most successful intervention and a necessary component to effective social prescribing efforts.[27] Lonely patients may have negative automatic thoughts about potential social interactions, which prevent them from engaging socially. Cognitive behavioral therapy can direct patients to not accept these maladaptive cognitions as truths, but rather to challenge and test these ideas.

With prolonged COVID-19 restrictions, individuals may struggle with reentry and experience anxiety or depression as they attempt to reintegrate back into relationships, workplace environments, and society in general. Screening for loneliness during clinic appointments can be a catalyst for these conversations which foster holistic patient care. The psychological and emotional impacts of the pandemic must be considered alongside the physical effects. Adopting routine brief screening protocols for potential pandemic-induced psychological impacts, such as loneliness, can identify a patient in crisis and lead to beneficial consultations and interventions for patient well-being.

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