Survey

Evidence-informed and targeted public health interventions are required to reduce the broader behavioural health impact of loneliness and social isolation due to the COVID-19 pandemic

10.1136/ebnurs-2020-103384

Akhtar Ebrahimi Ghassemi,[1] Parastou Azadeh Ranjbar[2]

[1]Department of Nursing, Hartwick College, Oneonta, New York, USA, [2]College of Medicine, Drexel University, Philadelphia, Pennsylvania, USA

Correspondence to: Dr Akhtar Ebrahimi Ghassemi, Hartwick College, Oneonta, NY 13820, USA; ghassemia@hartwick.edu

Commentary on: Bu, F, Steptoe, A, Fancourt, D. Loneliness during a strict lockdown: Trajectories and predictors during the COVID-19 pandemic in 38,217 United Kingdom adults. Soc Sci Med., 2020; https://doi.org/10.1016/j.socscimed.2020.113521

Implications for practice and research

► Developing targeted public health interventions to identify larger behavioural health impacts of loneliness due to COVID-19 lockdown are required, and these evidence-informed measures should help mitigate loneliness and improve mental health outcomes in high-risk populations during pandemics.

► Future research should focus on developing loneliness scales using surveys tailored to assessing different dimensions of loneliness due to the COVID-19 pandemic.

Context

The COVID-19 pandemic initiated a global lockdown and introduced social distancing policies limiting face-to-face activities and social interaction. With growing research on loneliness, and its associations with potential risk of mental illness, Bu et al examined the growth trajectories and predictors of loneliness during the pandemic lockdown.[1]

Methods

Using stratified sampling on data from 38 217 UK adults, in the University College of London COVID-19 Social Study, Bu et al examined whether loneliness levels changed during the strict lockdown period.[1] The authors used the three-item University of California, Los Angeles (UCLA-3) loneliness scale and employed growth mixture modelling to explore the latent classes of loneliness growth trajectories and predictors in a stratified sample in term of gender, age, ethnicity, education and geographical location.[1]

Findings

Based on the analysis, four groups with a loneliness level ranging from low to high were identified.[1] 'Younger adults (aged 18–29) (OR=2.17–6.81), women (OR=1.59), people with low income (OR=1.3), the economically inactive (OR=1.3–2.04, and people with mental health conditions (OR=5.32) were more likely to be in highest loneliness class. Moreover, having more close friends, living with others in a rural area, and access to greater support were protective.'[1]

Commentary

The COVID-19 pandemic has identified a rising need for the development of stronger evidence-based practices that combat social isolation and expand social contacts in ways that overcome new obstacles to human connection, such as social distancing.[2 3] Although loneliness is a widespread public health problem[3] that negatively impacts quality of life and mental health, screening tools to evaluate loneliness require further adaptation to pandemic circumstances. Bu et al, identified certain social factors including perceived social support, living with others, and having close friends to be protective in the lockdown period.[1] Their work lays the groundwork for future research into creation of more informed loneliness screening tools and preventative mental health interventions in pandemic lockdowns. While loneliness has been associated with many adverse effects, the researchers have much to learn about defining and measuring loneliness. Bu et al administered the UCLA-3 and asked participants to respond based on their experience during the pandemic.[1] However, because loneliness is a subjective construct,[3] using a self-report tool can be challenging in both past and present.[1 4] Further, there is no way of knowing whether participant responses were affected by the pandemic due to the generality of the survey questions and sampling bias. Additionally, the brevity of the UCLA-3 scale fails to clearly delineate between specific dimensions of loneliness (eg, social vs emotional loneliness[2]). Ideally, a loneliness survey should also include questions on isolation, mental health symptoms and social support to address maladaptive cognition during the pandemic lockdown.[2 5] Future research should focus on creating reliable and valid loneliness scales to understand the larger mental health implications of loneliness during pandemics.[5] Additionally, it is critical to identify the interrelated factors contributing to loneliness for cultivating targeted strategies that prevent psychiatric illnesses in high-risk populations.[2 5] Some proposed interventions may include enhancing social support, increasing opportunities for social interactions, addressing maladaptive cognition and safeguarding the availability of resources.[4]

Competing interests None declared.

Provenance and peer review Commissioned; internally peer reviewed.

Check for updates

References

1 Bu F, Steptoe A, Fancourt D. Loneliness during a strict lockdown: trajectories and predictors during the COVID-19 pandemic in 38,217 United Kingdom adults. *Soc Sci Med* 2020;**265**:113521.

2 Van Orden KA. Considering the Impact of Research Assessments: A Commentary on "COVID-19 Related Loneliness and Psychiatric Symptoms Among Older Adults: The Buffering Role of Subjective Age". *Am J Geriatr Psychiatry* 2020;**28**:1205–7.

3 Holt-Lunstad J, Smith TB, Baker M, *et al*. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspect Psychol Sci* 2015;**10**:227–37.

4 Jeste DV, Lee EE, Cacioppo S. Battling the modern behavioral epidemic of loneliness: suggestions for research and interventions. *JAMA Psychiatry* 2020;**77**:553–554 https://escholarship.org/uc/item/47n6790s

5 Saltzman LY, Hansel TC, Bordnick PS. Loneliness, isolation, and social support factors in post-COVID-19 mental health. *Psychol Trauma* 2020;**12**:S55–7.