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Research Article

The Lived Experience of Already-Lonely Older Adults During COVID-19

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Abstract

Background and Objectives: From the outset of the coronavirus disease 2019 (COVID-19) pandemic, analysts warned that older populations, due to their age, chronic illnesses, and lack of technological facility, would suffer disproportionately from loneliness as they sheltered in place indefinitely. Several studies have recently been published on the impact of COVID-19-related loneliness among older populations, but little has been written about the experiences of already-lonely older individuals; those who had lived with persistent loneliness before the advent of COVID-19. This qualitative study sought to understand how already-lonely older individuals navigated and endured the social isolation of the pandemic.

Research Design and Methods: Twelve semistructured interviews were conducted with individuals aged 65 or older who scored a 6 or above on the 3-item UCLA Loneliness Risk screening tool. Interviews were coded using the constant comparative method. Themes and understandings of loneliness that reoccurred within and across interviews were identified and collected.

Results: Already-isolated older interviewees did not necessarily experience the abject loneliness hypothesized by analysts. Most interviewees used longstanding arrangements, in place to mitigate loneliness and endure social isolation, to manage the social deprivation of COVID-19. As a result, their loneliness did not compound during long bouts of mandated social isolation. To the contrary, loneliness during the pandemic appeared to carry a new valence for interviewees, as COVID-19 imbued their isolation with new meaning, rendering their loneliness necessary and responsible.

Discussion and Implications: Exploring individuals' subjective perceptions of loneliness can help provide a deeper understanding of what it means to be isolated and alone during COVID-19 and aid in designing strategies to mitigate loneliness.

Keywords: Loneliness, Pandemic, Qualitative methods, Social isolation

Background and Objectives

Loneliness and social isolation—two separate, but related phenomena—are common and complex determinants of health. Perceived feelings of loneliness and an objective lack of significant social ties have been associated with a host of health problems including depression, obesity, cognitive decline, and cardiovascular disease (Domènech-Abella et al., 2019; Shankar, McMunn, James Banks, & Steptoe, 2011). Lonely individuals often live shorter lives, have lower cognitive function, and are more likely to be depressed and develop heart disease than their socially integrated peers (Santini et al., 2020; Valtorta, Kanaan, Gilbody, Ronzi, & Hanratty, 2016).

Loneliness and social isolation are often precipitated by chronic health conditions, mobility issues, and sensory

impairments (Mick, Parfyonov, Wittich, Phillips, & Pichora-Fuller, 2018). Consequently, older adults are particularly vulnerable to the subjective distress that accompanies a life of isolation. Chronic loneliness among older Americans has long been acknowledged as a silent public health crisis by U.S. health analysts (Holt-Lunstad, 2017). Estimates suggest that roughly a quarter of individuals older than 65 years are socially isolated (Flowers et al., 2017), a population already disproportionately at risk of loneliness due to retirement, the death of spouses, and the decline of social networks (Maharani, Pendleton, & Leroi, 2019; Victor & Bowling, 2012).

Many analysts—gerontologists among them—predicted that coronavirus disease 2019 (COVID-19) would be accompanied by a shadow pandemic of loneliness, warning of the unforeseen health consequences among older adults who may, due to their age and health conditions, have to shelter in place indefinitely (Berg-Weger & Morley, 2020; Marziali et al., 2020; Saltzman et al., 2020). These analysts warned that the measures meant to protect older people, including the physical distancing and social isolation required of stay-at-home orders, might lead to depression, anxiety, and despair, and exacerbate cognitive decline (Armitage & Nellums, 2020; Chu et al., 2020; Macdonald & Hülür, 2021; Marziali et al., 2020; Patel & Clark-Ginsberg, 2020; Plagg, Engl, Piccoliori, & Eisendle, 2020; Smith & Lim, 2020).

Yet, some early, large-scale studies examining social isolation among older people found that loneliness did not necessarily increase during the pandemic (Benke et al., 2020; Kotwal et al., 2021; Luchetti et al., 2020), or if it did increase, it did not affect mental health (Van Tilburg et al., 2020). Other studies found resilience common among, and in some cases exclusive to, older adults during the pandemic (Lind et al., 2021; Minahan et al., 2020).

As a population, already-lonely older adults often inhabit the intersection of a confluence of vulnerabilities—chronic health problems, mobility impairments, restricted activity, etc.—that are strong predictors of further loneliness (Cohen-Mansfield et al., 2016; Dahlberg & McKee, 2014; Theeke, 2009). Yet studies have found that older adults re-envision and revise their expectations of social connectedness in the face of changing social circumstances (Schnittker 2007), a phenomenon that has been reaffirmed during the COVID-19 pandemic (Beam & Kim, 2020; Fried et al., 2020). Our research sought to understand how COVID-19 affected already-isolated older individuals, an ostensibly vulnerable subset of a population already at risk for loneliness.

Research Design and Methods

Twelve semistructured interviews were conducted with patients of a large health care system, aged 65 and older, who had—during their discharge planning assessment at a local hospital—scored a 6 or higher on the UCLA loneliness risk screening tool, indicating a high degree of loneliness (Russell, 1996). A. J. Caprio, a geriatrician, and H. Bundy, a medical anthropologist, collaborated to produce the interview guide. The guides were designed to query matters of emotional, rather than social or existential, loneliness, as emotional loneliness often corresponds most closely to lay conceptions of what it means to be lonely (Van Tilburg, 2020). Interviews began with "Grand Tour" questions (Leech, 2002), general inquiries meant to facilitate conversation and explore a respondent's priorities and worldview ("Could you describe a typical day for me these days?"; "Has your life changed any since the pandemic began?"). These Grand Tour questions were followed by more specific questions asking, among other things, how often interviewees saw or talked to other people, how interviewees protected themselves against infection, how they obtained groceries and medication, how the pandemic had affected their mental health, and whether they felt more alone since the advent of COVID-19 (see Supplementary Figure 1 for full interview guide). These lines of inquiry were informed by a burgeoning literature concerned with loneliness and social isolation during the COVID-19 era and by older studies that had examined the mental health consequences of other early twenty-first century pandemics (Douglas et al., 2009; Kim et al., 2018; Maunder et al., 2003). Following De Jong Gierveld (1998), we defined loneliness as the subjective and unpleasant experience that arises from dissatisfaction with the frequency or intimacy of an individual's relationships.

Interviews were conducted via telephone and these phone interviews were audio-recorded. The age of interviewees ranged from 65 to 92 years, with an average age of 73. Seven women and five men participated in the study. Three of the respondents were African American, the other nine were White. Half of the respondents lived in rural areas. (For a list of interviewees' main diagnoses see Supplementary Figure 2. Throughout this article, the first mention of an interviewee will include their age and main diagnosis.)

All interviewees shared a common loneliness, but the degree to which respondents lived in social isolation varied; while most interviewees lived alone, one respondent cohabitated with a spouse, and another had family living next door. Half of the study's respondents had family living in the same county, but as Ms. B. (69, Diabetes) pointed out, proximity to family did not necessarily allay loneliness. "Sometimes it's good to have someone else to talk to other than family," she noted. Some interviewees had lived alone for years. Others were recently housebound. The death of a partner or spouse was the most commonly mentioned reason for their social isolation.

Respondents differed significantly in their Internet use. Of the 12 interviewees, six only rarely or never used the Internet. "I'm just not a computer person, so I'm on the phone," Ms. B., one of the six, noted. Conversely, a few interviewees spent a significant amount of every day online.

"Basically, I spend most of my time on the Internet," Mr. W. (67, Coronary artery disease) said, explaining how he filled his days after a recent heart attack.

Interviewees were recruited using a convenience sample, a nonprobability sampling strategy commonly used for studying reclusive and reluctant populations (Bernard, 2017; Guest et al., 2006). This sampling strategy was deployed among a population of older adults that had been identified as at risk for loneliness or social isolation during their discharge assessment from a local hospital system. H. M. Lee, a social worker in regular contact with these socially isolated older adults, identified and contacted potential interviewees. The 12 interviews were conducted by H. Bundy. The study's sample size was arrived at after considering the project's narrow study aim—to determine how already-lonely older adults had been affected by the pandemic—and the nature of the targeted interviewee population—all older adults experiencing loneliness prior to the COVID-19 pandemic (Malterud et al., 2016).

The recorded interviews were deidentified and then analyzed using ATLAS.ti. Our analytical approach was inductive—building theory on patterns found in the data—as such analyses are typically well suited for exploratory examinations of novel or understudied social phenomena. We began by coding interviews at the question level, which allowed us to compare all interviewee answers to a specific question. First, responses were collected and collated; then, if warranted, question-level responses were subcoded. Answers to Question 1B: "Are you more lonely or isolated since COVID?," for example, were divided into smaller codes: "1B_MORE LONELY," "1B_LESS LONELY," or "1B_NO CHANGE," depending on a respondent's answer.

Question-level coding provided a broad and basic overview of the interview data. These "horizontal" readings—examinations of specific lines of inquiry *across* interviews—were followed by "vertical" explorations, during which individual interviews were read in their entirety. The codes derived from the latter readings were not tied to specific questions. For example, the code "PHYSICAL MOBILITY ISSUES," used to indicate any time an interviewee mentioned having difficulty getting around, was commonly found in answers to Question 5A: "Do you have any mobility issues?" But mentions of hampered mobility could also come up elsewhere in interviews. For example, when asked "How do you connect with others?" (Question 4), Ms. T. (88, Chronic obstructive pulmonary disease [COPD]) explained that her COPD significantly limited her ability to get around. This section of text was coded for "PHYSICAL MOBILITY ISSUES."

This vertical analysis was done using the constant comparative method, a "scrutiny-based technique" (Ryan & Bernard, 2003, p. 101) foundational to grounded theory, an approach in which theory building is based on empirical analysis rather than deductive inference (Hallberg, 2006). Using this comparative method, codes are produced inductively and iteratively, as early codes often have a contingent and provisional quality and must be delineated and refined through a continual comparison with preceding and subsequent data (Boeije, 2002).

During these vertical readings, codes were often used to paraphrase and summarize passages. For example, when Ms. T., while answering another question, offered an unprompted explanation of how she had come to live alone and feel socially isolated ("All my friends, my support system, live away. I came back here to take care of my mom … and I thought I would move away. But that didn't happen. And so, I don't have the support system here I had before I moved here."), we created the code ORIGINS OF SOCIAL ISOLATION/LONELINESS. This code was used in several subsequent interviews. Other codes were used as markers for emerging patterns that might later be developed into themes. When Mr. H. (92, Depression) said of COVID-19, "Once you're diagnosed with it, you might as well go on and be buried with it, the way it looks," we tagged the sentence with the code CONCEPTIONS OF COVID, which was used several more times throughout the remaining interviews.

Throughout our analysis, the ever-growing literature on loneliness among older Americans during COVID-19 inevitably started to inform our work and we began to review interviews with the emergent findings, theories, and concepts of this burgeoning body of literature in mind—sensitized to new understandings of, and emerging questions surrounding, COVID-19's impact on the loneliness of older adults. For example, articles examining the relationship between the loneliness of sheltering in place and depression (Killgore et al., 2020) and the health risks of COVID-19 countermeasures (Chu et al., 2020) prompted us to read through the interviews again, alert to mentions of mental and physical ill-health that interviewees attributed to recommended practices of self-isolation.

Themes, summative propositions used to make sense of and connect recurring ideas in a study (Bradley et al., 2007), were also developed using the constant comparative method, which provided a framework to understand the commonalities and differences within and among interviews, as the method is also a method of identifying contrasts. Themes were induced—inferred from particular, reoccurring instances—through a process of "fragmentation" (Boeije, 2002), the repeated parsing and partitioned of interview data for relevance to our research questions.

According to debriefing notes, our study's four salient themes became apparent early in the analysis, after approximately six interviews. No new themes were discovered in the following six interviews. By the 12th interview, responses related to the four themes had become consistently redundant, and it was determined that thematic saturation had been reached.

This study was approved by the Atrium Health Institutional Review Board.

Results

Four key themes were identified from the interviews. (a) The social isolation of COVID-19 did not exacerbate the loneliness of the already-isolated interviewees. (b) Interviewees, living in protracted social isolation and experiencing persistent loneliness, managed to endure the exigencies of the COVID-19 with longstanding arrangements that were in place before the pandemic. (c) Most interviewees framed their loneliness during COVID-19 in terms of necessity and responsibility, rather than pathology and shame. (d) Respondent's COVID-19-related anxieties revolved around the health of their families and acquaintances and the state of the world in general, rather than their own well-being.

Loneliness Did Not Necessarily Compound

Staying at home and having to shelter in place were nothing new to many interviewees. When asked if she felt more alone since the pandemic, Ms. L. (70, Hepatitis C) replied, "I don't think so. Like I said, I was never that type of person that loved to really go out." Ms. A. (77, COPD)—housebound as a result of her chronic health conditions—when asked about the impact of the pandemic on her life replied, "It's not been a whole lot, because I was already sitting around the house a whole lot anyway, since I got my oxygen so bad and all I don't drive any more. It's basically the same, pretty well … I'd pretty well be like this anyway with COVID or without COVID." This is not to suggest that interviewees were not lonely, or depressed—they were, without exception—yet the already-lonely older patients interviewed did not report loneliness becoming worse during the lockdowns and mandated social distancing of the pandemic, as might be expected. As Mr. M. (66, Cancer) noted, "I'm certainly depressed, but it's not necessarily related to the virus. When you are in the shape I'm in, you can't walk … all that's depressing. But I won't say it's to the virus." Ms. G. (80, Arthritis), similarly, reported feeling lonely, but did not attribute her loneliness to the pandemic, "The virus has not affected me at all, in any way."

Managing Loneliness and Enduring Social Isolation

Because interviewees had lived insular or homebound lives before the pandemic, most already had arrangements in place to manage loneliness and endure social isolation when COVID-19 appeared. As a result, most interviewees saw few disruptions in their daily lives during the pandemic. Home health aides and caregivers came as they had before, friends continued to bring groceries, and family members took interviewees to doctor's appointments. "Anything I need, [my friends] get it for me. I don't go out," Ms. C. (66, Atrial fibrillation) said. Ms. L. concurred, saying she had not been particularly inconvenienced by the pandemic, "My friend takes me [to the store], or my daughter gets groceries and stuff." Interviewees had developed regimens and processes to manage and endure their socially isolated lives. Mr. W. had been getting several months' medications at a time prior to COVID-19 and did not feel worried about getting his medications, "I like to take care of my own medicine because I know what I'm supposed to take. I segregate three months' worth in little containers, so I know what to take." Other interviewees had medicines delivered via mail.

Loneliness, Protective, and Responsible

Interviewees reported being lonely during the pandemic, but for many, loneliness carried new meaning, as COVID-19 rendered their social isolation necessary, and a matter of responsibility and vigilance. Loneliness was a burden, but now also a precaution and a necessity. Mr. P. (65, Chronic kidney disease) considered the quarantine measures that kept him from visiting his family and kept him lonely reasonable and responsible, "I don't get to go see my sister and my ex-wife in the rest home. It's really kept me from seeing them. I was going for a while, every day. Then they came up with no visitors what-so-ever. But it's a good thing as far as that goes." For many interviewees, the loneliness that accompanied the pandemic was now a matter of conscientious self-isolation. Ms. B., a diabetic, adhered to a strict quarantine due to her health: "If I got the coronavirus I would probably not live through it and I certainly wouldn't be a candidate for a ventilator at my age, I wouldn't think. Yeah, I get lonely around here sometimes. But that's just the world I'm in now."

Most interviewees did not consider themselves lonelier, despite objectively having less social contact since the pandemic. "Yeah, my life has changed," Ms. B. said, "but not for the bad. You have to wear a mask when you go out. Have to be careful. Stay out the crowds. I get a little lonesome once in a while, but I take it as it comes." Many interviewees noted that depression, which had accompanied their personal loneliness, had become commonplace in the era of COVID-19 and was part of modern life. "I am very aware of the probability of being depressed in almost anyone today," Ms. D. (65, Hypertension) noted, "I think you have to work, anybody today, *not* to be depressed." Ms. C. attributed this ostensibly widespread depression to the fact that many people were likely experiencing the pandemic as she was, "Don't have nowhere to go. You just sit around and do chores and watch TV."

The Anxieties of COVID-19

Isolated, and largely protected from infection, interviewees felt relatively safe, but fretted about their families and acquaintances. Ms. G. worried about her children and grandchildren: "It scares me to think about my kids out there. I know I can stay in the house, and stay in my room

away from people, but my family can't. They have to work. They have to go to school. I worry about it a lot."

Most interviewees noted that they were not anxious about their own mental health, which had remained relatively stable during the pandemic, but instead worried about the state of the world and reported feeling disheartened by what they considered to be the irresponsibility of the people around them. "This is the worst thing that has ever happened in my 77 years," Ms. A. said. "There's nothing good happening now. That in itself is hard to deal with." Interviewees also became frustrated with what they considered to be the irresponsibility of those around them. "I was very disappointed," Mr. F. (76, Chronic pain) said, "One girl came [without a mask] and sat right beside me and I said, 'I don't want to be rude, but you are sitting entirely too close to me'."

Discussion and Implications

The "new normal" of COVID-19, life lived in various degrees of social deprivation, was not unfamiliar to interviewees. The results presented here suggest that older, already-isolated individuals may be relatively well prepared to endure the social isolation of lockdowns and stay-at-home order, as interviewees did not generally experience the sudden, unforeseen changes that were characteristic of many other people's early COVID-19 experiences (Brooks et al., 2020). Furthermore, while some studies of COVID-19-related isolation found "surge(s) of self-reported loneliness" (Killgore et al., 2020, p. 1), the older, isolated individuals interviewed in this study did not report feeling lonelier than before the pandemic. The transient loneliness related to COVID-19, a bounded and circumstantial condition, did not appear to exacerbate the persistent loneliness of already-lonely interviewees. This finding is corroborated by a recent mixed-methods longitudinal study of 151 older adults that found that already-isolated individuals—individuals isolated due to medical conditions—reported no difference in their loneliness during the pandemic (Kotwal et al., 2021). Our results also appear to support the hypothesis put forward by a recent study (Luchetti et al., 2020) suggesting that being part of a communal effort to combat the spread of the virus may increase resilience to loneliness among individuals at risk for social isolation.

This is not to suggest that calls for action and caution related to COVID-19-related loneliness are exaggerated, as analysts have rightly stressed the physiological and emotional risks of physical and social distancing (Chu et al., 2020; Patel & Clark-Ginsberg, 2020; Portacolone et al., 2021; Sepúlveda-Loyola et al., 2020). Instead, the results of this study serve as a reminder that experiences of loneliness are inflected through cultural expectations—determined by societal norms and shaped by individual worldviews (Ozawa-de Silva & Parsons, 2020). Interviewees presented their pandemic-related loneliness as a voluntary, if painful, withdrawal. As a result, study participants appeared to be content with fewer social ties during the pandemic, but still felt a lack of close emotional relationships.

This research suggests that among some older socially isolated individuals, expectations of, and aspirations for, social relationships have shifted with the advent of COVID-19. As a result, loneliness as a condition appears to have acquired new meaning among some already-lonely individuals, the pandemic having rendered social isolation common and a matter of caution, rather than pathological and self-inflicted. This unexpected finding may be less surprising in light of cross-cultural studies that have shown that when individuals understand their loneliness as a personal failing, their distress is exacerbated (De Jong Gierveld et al., 2015; Rokach, 2007). Respondents in this study, by contrast, tended to talk of loneliness as a newly normative condition affecting the entire world.

The impacts of COVID-19 are revealing themselves to be myriad, far-reaching, and unanticipated, making it critical to examine what effects stay-at-home orders, mandated social distancing, and a possible loss of social connections may have on the health and well-being of already vulnerable, socially isolated individuals. Using qualitative interviews, this research allowed older, isolated individuals to explain, in their own words, how they have understood and experienced loneliness and isolation during this period of pandemic. Qualitative explorations of individuals' subjective perceptions of this important determinant of health can help contextualize complex health-related behaviors, provide a deeper understanding of what it means to be isolated and alone during the COVID-19 pandemic, and aid in designing strategies to mitigate loneliness.

We believed this work to be particularly timely, for in op-eds and studies of COVID-19, the loneliness of older adults is often a black box—an opaque and unvarying phenomenon—a "behavioral toxin" (Jeste et al., 2020) either present or absent. Contributions to this growing body of literature, which are often accompanied by forewarnings of the outsized impact pandemic-related loneliness will have on older populations, tend to represent older adults as disproportionately and monolithically vulnerable. As shown above, the already-lonely older adults interviewed for this study existed at the intersection of several established vulnerabilities, yet did not fare as poorly as many of their contemporaries. Generally, research has shown that "macro-level stressors" (Whitehead & Torossian, 2021) such as financial crises and natural disasters have negative impacts on the psychological well-being of older adults (Parker et al., 2016; Wilkinson, 2016). And while some studies found that disasters can have a disproportionately negative effect on older adults (Tracy & Galea, 2006), other research suggests that older populations are not always inherently more endangered by disasters (Rafiey et al., 2016). Our research seems to corroborate this latter work, as our interviews showed that already-lonely individuals are not necessarily as vulnerable as the sum of their circumstances suggests. In light of this result, we believe that further study is warranted to determine whether the pandemic-related indices and interventions used to identify and mitigate loneliness among older adults are appropriate for the subset of

the population that has experienced persistent and preexistent loneliness.

Limitations and Conclusions

Qualitative interviewing relies heavily on recall, comprehension, and the ability to communicate, making the interview process potentially onerous or distressing for interviewees experiencing cognitive or hearing impairments. Conducting interviews over the phone—a precaution we took to ensure interviewees' safety—can make matters worse. However, difficulties of cognition and communication should not preclude researchers from attempting to elicit the lived experience of older persons living with cognitive decline or hearing loss, which included participants of this study; the alternative would risk excluding the voices of such patients altogether. To accommodate study participants, patient-interviewees were given the option to suspend interviews temporarily at any point during the interview process and take them up another time. The interviewer also reiterated the patient's rights—first presented during the consent process—midway through the interview. These rights include the right to refuse to answer any question and the right to suspend or terminate the interview at any point.

Despite this limitation, we believe that our study provides important insights concerning the complexion of loneliness among older adults during the COVID-19 pandemic. An individual's subjective loneliness reveals in its painful lacking their personal understanding of what plentiful, attainable, and fulfilling relationships are. We found that for some already-lonely older adults, the pandemic had reconstituted their conception of loneliness and that the loneliness experienced by our interviewees was not additive; that is, the distress of being alone was not exacerbated by social distancing and stay-at-home orders. How already-lonely older adults relativize their loneliness in the face of large-scale stressors deserves more study.

Supplementary Material

Supplementary data are available at *The Gerontologist* online.

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Conflict of Interest

None declared.

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