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## Editorial

## Loneliness and Isolation in Long-term Care and the COVID-19 Pandemic

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Social isolation (the objective state of having few social relationships or infrequent social contact with others) and loneliness (a subjective feeling of being isolated) are serious yet underappreciated public health risks that affect a significant portion of the adult population. Social isolation is a risk factor for development of loneliness, but some persons enjoy it (eg, hermits). Conversely, having social relationships does not ensure that loneliness will not develop, because the social relationship has to be meaningful. Many people feel lonely under the best of circumstances. Approximately one-quarter (24%) of community-dwelling Americans aged 65 and older are considered to be socially isolated, and a significant proportion of adults in the United States report feeling lonely (35% of adults aged 45 and older and 43% of adults aged 60 and older).<sup>1</sup>

Loneliness is even more common in long-term care institutions. The prevalence of severe loneliness among older people living in care homes is at least double that of community-dwelling populations: 22% to 42% for the resident population compared with 10% for the community population.<sup>2</sup> One study found that more than half of nursing home residents without cognitive impairment reported feeling lonely.<sup>3</sup> A study in Malaysian nursing homes using the UCLA loneliness scale found that all residents felt lonely: 25% moderately and 75% severely.<sup>4</sup> Unfulfilled need for meaningful relationships and losing their self-determination because of institutionalization play crucial roles in feelings of loneliness.<sup>5</sup> Several books provide information about activities that may decrease loneliness.<sup>6–8</sup> Interventions that were found to successfully decrease loneliness are laughter therapy, horticultural therapy, and reminiscence therapy.<sup>9</sup> However, some activities may not be feasible during the COVID-19 pandemic.

Feeling of loneliness has many deleterious consequences. They include increased risk of depression, alcoholism, suicidal thoughts, aggressive behaviors, anxiety, and impulsivity.<sup>1</sup> Some studies found that loneliness is also risk factor for cognitive decline and progression of Alzheimer's disease, recurrent stroke, obesity, elevated blood pressure, and mortality.<sup>10</sup> Lonely older people may be burdened by more symptoms before death and may be exposed to more intense end-of-life care compared with nonlonely people.<sup>11</sup>

Loneliness has 3 dimensions. The first is personal loneliness, which is often related to the absence of a significant person like a spouse or

partner who provides emotional support and is someone who affirms one's value as a person. The significant someone could be a pet, because pet ownership decreases loneliness.<sup>12</sup> The second dimension of loneliness is absence of a sympathy group, which can include 15 to 50 people who are seen regularly. This may be a card group, bridge or canasta, or another popular game, Bingo, which many retired seniors enjoy. The third dimension is a lack of an active network group, consisting of from 150 to 1500 people, who provide support just by being together in a group. Church services, rotary meetings, and the Lions Club are good examples of these larger groups.

In all countries affected by COVID-19, the message that is being sent by government officials and medical experts is “stay at home” and “isolate in place.” The isolation is especially difficult for people living in nursing homes and assisted living communities. Most facilities have asked that no one enter the facilities unless they work there because there is a high risk that COVID-19 would spread rapidly once it is introduced. Group activities have been canceled and, in many facilities, residents are eating in their rooms, as all communal dining has been stopped. Although prohibiting group activities will decrease the risk of spreading the COVID-19 infection in nursing homes, it significantly increases the isolation and resulting loneliness of residents.<sup>13</sup>

Long-term care facilities also prohibit visits from outside, including visits by family members. This is especially burdensome for residents with cognitive impairment and dementia. Many family members of these residents visit often, sometimes every day, bring food, and help the residents with eating and drinking.<sup>14</sup> If they cannot visit, they may be afraid that the resident will no longer recognize them.

The following ideas are easy to implement, with little or no cost or hiring additional staff, and can decrease the loneliness of residents in nursing homes or assisted living communities:

1. Name tags. Ask residents and staff if they would wear a plain name tag, white with black Times New Roman lettering. The font should be at least one-half inch high. The name tag will have the name the person wants to be called on it. Our name tags would have Dr. Volicer or Joyce on them. The staff will also need to wear their “official” facility name tag, but they are very difficult for an older person with some vision impairment to read. Wearing a name tag that can easily be read helps to make a connection between the staff and residents.
2. Ask family members of residents who could operate a personal computer or iPad to purchase one to help them stay connected

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with each other. Some libraries have inexpensive laptops for sale and may have a few to give away. When the resident has a computer or iPad in his or her room, a Skype or Zoom meeting can be arranged. These meetings can be coordinated with the activity staff, so they can help set up the computer or iPad. iN2L technology may facilitate online<sup>15</sup> connections

3. Families may not be allowed to come into the facility; however, they can stay connected in several ways. Ask families to have at least 1 family member call a resident in the morning to say, “good morning,” and another to call late in the afternoon or early evening to say, “good night.” This is assuming that residents have a phone in their rooms and can answer it. If you have residents with no active family members, you may be able to recruit volunteers to call residents.
4. Families can come to the window in the resident’s room and sing to the resident or hold signs sending love to the resident. If the resident’s room is not on the ground floor, the family can arrange a time convenient for the staff to take the resident to the first floor where the resident can look out a window and see his or her family.
5. Urge families to send cards and letters. Residents also love to receive “art work” from their grandchildren or great grandchildren. Letters can include copies of pictures from the past that residents may enjoy seeing again.
6. Group religious services have been discontinued; however, many are now on the Internet or television. The activity staff will have a social history of each resident and will know the resident’s religion. If it would be comforting for the resident, staff can make sure the mass or other religious service is on the resident’s television or iPad.
7. Some residents with dementia are comforted with realistic toy dogs, cats, or life-like-looking dolls. If a resident develops a fondness for any of them, the family might agree to purchase one. It seems that men particularly like dogs. They can be purchased on [amazon.com](https://www.amazon.com) and are less than \$20. Stuffed animals or dolls cannot be shared because of infection-control issues. There is also some evidence that robotic animals (robopets) may be effective in decreasing loneliness of older adults in a residential care setting.<sup>16</sup>
8. Simulated Presence Therapy is another way by which families can keep in touch with a resident. It involves the family member making a recording in which questions are asked, such as, “I remember when you lived in Concord, New Hampshire, do you remember what you did with your Girl Scout troop?” Then the recording is silent, so the resident can say something. The recording could be similar to a phone call, in which the family member can ask about pleasant experiences in the past and leave a space for the resident’s answers. If the resident has dementia, the recording could be played repeatedly, because the resident will forget that she or he already listened to it. A study found that Simulated Presence Therapy enhanced well-being of residents with dementia and decreased behavioral symptoms of dementia.<sup>17</sup>
9. The Activity Department might be encouraged to have items that can be sorted, like buttons or small pieces of fabric. Residents can be asked to help sort items and put them into small bowls. The resident sorting buttons must be a person who would not try to eat one, as this would be quite dangerous. Take

3 packs of cards and mix them up and ask a resident to sort them. Make sure the packs are very distinctive, so it will be easy to decide what pack each card belongs in and thank the resident when the task is completed. Nursing home residents often feel hopeless, as rarely does anyone thank them for doing something. This is a great opportunity to have a resident feel as if he or she is needed.

## Conclusions

Preventing loneliness in institutionalized persons is at least as important as helping them with personal hygiene. This is especially important during the COVID-19 pandemic when residents must be protected from contact with other individuals to reduce the risk of infection. Implementation of some of the strategies listed in this article requires education of staff members and supply of required items; however, this effort can significantly improve the quality of life of residents affected by pandemic restrictions.

## References

1. Blazer DG. The health and medical dimensions of social isolation and loneliness in older adults. Available at: <https://www.nationalacademies.org/our-work/the-health-and-medical-dimensions-of-social-isolation-and-loneliness-in-older-adults>. Accessed May 22, 2020.
2. Victor CR. Loneliness in care homes: A neglected area of research? *Aging Health* 2012;8:637–646.
3. Drageset J, Kirkevold M, Espehaug B. Loneliness and social support among nursing home residents without cognitive impairment: A questionnaire survey. *Int J Nurs Stud* 2011;48:611–619.
4. Aung KT, Nurumal MS, Syakihar WN, Bukhari W. Loneliness among elderly in nursing homes. *International Journal for Studies on Children, Women, Elderly and Disabled* 2020;2:72–78.
5. Paque K, Bastiaens H, Van Bogaert P, Dilles T. Living in a nursing home: A phenomenological study exploring residents’ loneliness and other feelings. *Scand J Caring Sci* 2018;32:1477–1484.
6. Bell V, Troxel D. *The Best Friend Approach to Alzheimer’s Care*. Baltimore, MD: Health Professions Press; 1996.
7. Einberger K, Sellick J. *Brain Flexers*. Baltimore, MD: Health Professions Press; 2015.
8. Feil N, de Klerk-Rubin V. *The Validation Breakthrough*. Baltimore, MD: Health Professions Press; 1993.
9. Quan NG, Lohman MC, Resciniti NV, Friedman DB. A systematic review of interventions for loneliness among older adults living in long-term care facilities. *Aging Ment Health* 2019 Oct 11 [Epub ahead of print].
10. Cacioppo S, Grippo AJ, London S, et al. Loneliness: Clinical imports and interventions. *Perspect Psychol Sci* 2015;10:238–249.
11. Abedini NC, Choi H, Wei MY, et al. The relationship of loneliness to end-of-life experience in older Americans: A cohort study. *J Am Geriatr Soc* 2020;68:1064–1071.
12. Gan GZH, Hill A-M, Yeung P, et al. Pet ownership and its influence on mental health in older adults. *Aging Ment Health* 2019 Jun 27 [Epub ahead of print].
13. Span P. Just What older people didn’t need: More isolation. Available at: <https://www.nytimes.com/2020/04/13/health/coronavirus-elderly-isolation-loneliness.html>. Accessed May 22, 2020.
14. Dewey C. For my grandmother, who has Alzheimer’s, food is memory and connection. Now I’m not allowed to cook for her—or even visit. Available at: <https://thecounter.org/covid-19-essay-grandmother-alzheimers-food-eating-in/>. Accessed May 22, 2020.
15. Taylor L, York J. The leader in person-centered engagement technology for senior living. Available at: <https://in2l.com/about-in2l/>. Accessed May 22, 2020.
16. Abbott R, Orr N, McGill P, et al. How do “robopets” impact the health and well-being of residents in care homes? A systematic review of qualitative and quantitative evidence. *Int J Older People Nurs* 2019;14:e12239.
17. Camberg L, Woods P, Ooi WL, et al. Evaluation of simulated presence: A personalized approach to enhance well-being in persons with Alzheimer’s disease. *J Am Geriatr Soc* 1999;47:446–452.