



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.ajgponline.org

Special Issue Article

Strategies to Promote Social Connections Among Older Adults During “Social Distancing” Restrictions

**Kimberly A. Van Orden, Ph.D., Emily Bower, Ph.D., Julie Lutz, Ph.D.,
Caroline Silva, Ph.D., Autumn M. Gallegos, Ph.D., Carol A. Podgorski, Ph.D.,
Elizabeth J. Santos, M.D., Yeates Conwell, M.D.**

ARTICLE INFO

Article history:

Received March, 26 2020

Revised April, 22 2020

Accepted May, 5 2020

Key Words:

Social connections
social isolation
loneliness
COVID-19
cognitive-behavioral therapy
psychotherapy

ABSTRACT

Older age and medical comorbidity are factors associated with more severe illness and risk of death due to COVID-19 infection. Social distancing is an important public health strategy for controlling the spread of the virus and minimizing its impact on the older adult population. It comes at a cost, however. Loneliness is associated with myriad adverse health outcomes, one of which is impaired immune functioning, which adds even greater risk for coronavirus infection, complications and death. Older adults, therefore, are at compound risk, making effective management of loneliness and social isolation in our older patients a high priority target for preventive intervention. In this paper, the authors describe a cognitive-behavioral framework for social connectedness, including evidence-informed strategies clinicians can use to help patients develop a “Connections Plan” to stay connected and promote their social, mental, and physical health during “social distancing” restrictions. This set of strategies can be provided during brief (30 minute) telephone sessions and is analogous to creating a “Safety Plan” for suicide risk. The approach is illustrated with three case examples. (Am J Geriatr Psychiatry 2020; ■■■:■■■-■■■)

Social connections are essential for health and well-being at all ages and may be especially important for promoting health in later life. Whereas declines in physical, sensory, and cognitive function are common with advancing age, social functioning

remains malleable and responsive to intervention throughout life. Lifespan developmental theories of socioemotional development suggest that relationship satisfaction and social well-being increase in later life¹ and are strengths that can be capitalized upon to

From the Department of Psychiatry, University of Rochester School of Medicine & Dentistry, Rochester, NY. Send correspondence and reprint requests to Kim Van Orden, Ph.D., Department of Psychiatry, University of Rochester School of Medicine & Dentistry, 300 Crittenden Blvd., Box Psych, Rochester, NY 14642-8409. e-mail: Kimberly_vanorden@urmc.rochester.edu

© 2020 American Association for Geriatric Psychiatry. Published by Elsevier Inc. All rights reserved.

<https://doi.org/10.1016/j.jagp.2020.05.004>

Strategies to Promote Social Connections Among Older Adults

promote mental health and well-being. In contrast, a lack of meaningful social connections—including “objective” social isolation (e.g., few social ties or low frequency of social interactions), social support, and loneliness²—are associated with reduced quality of life (well-being, depressive symptoms),^{3,4} unhealthy behaviors (smoking, unhealthy diet, and lack of exercise),^{5–7} and adverse health outcomes (cardiovascular disease, metabolic syndrome, hypertension, pain, fatigue, insomnia, depression, dementia, suicide, and all-cause mortality).^{3,6,8–14} The risk of premature mortality due to a lack of social connection is comparable to the risk due to maintaining an unhealthy diet, physical inactivity, alcohol misuse, and smoking.¹⁵ The importance of maintaining social connections is especially salient at the time this article is being prepared due to the COVID-19 pandemic and implementation of social distancing practices that are likely to negatively impact social connections for many older adults. Thus, we are writing this piece to provide a guide to clinicians who work with older adults on issues to consider regarding social connections as well as concrete actions to help patients maintain social health, and therefore, optimize their mental and physical health.

The concept of social connections as a central force in mental health is not new. At the beginning of the 20th century, Durkheim offered a sociological perspective on suicide, including the observation that changes in social dynamics at the societal level tracked closely with population-wide increases in suicide rates.¹⁶ This concept can be observed when considering changes in suicide rates in the wake of national tragedies: some tragedies are associated with reduced suicide rates, whereas others are associated with increased suicide rates.^{17,18} One hypothesis to describe this phenomenon is societal “pulling together” versus “pulling apart.” Pulling together may involve an increased sense of belonging to a community, of being “in it together,” and of being part of a larger whole, and has been posited to be a contributor to reduced rates of suicide following the assassination of President John F. Kennedy in 1963,¹⁹ the Challenger disaster in 1986,¹⁷ and the terrorist attacks of September 11, 2001.²⁰ It is important to note, however, that suicide rates following September 11, 2001 may differ across subgroups²¹ and that not all experts agree on how to best analyze and interpret the effects of national tragedies on suicide rates.²² In

contrast, tragedies that cause geographic displacement or social distancing (e.g., natural disasters, pandemics) may be associated with “pulling apart” effects in communities and contribute to increases in mental health problems and suicide. The 2003 SARS epidemic was associated with a significant increase in suicide deaths among older adult women in Hong Kong (but not young adults or older men) in the year after the outbreak, with the greatest number of suicide deaths occurring 1 month after the outbreak began when the greatest number of SARS cases were documented.²³ Fears of contracting the illness and thereby burdening family, as well as fears of social disconnection, were contributing factors to suicide deaths of older women in Hong Kong at this time.²⁴

Of course, changes in suicide rates at the population level do not directly apply to an individual patient (compare, ecological fallacy); rather, we discuss these findings here because they illustrate several essential points for clinicians to keep in mind: 1) social factors can and do shape health at both a population and individual level; 2) the presence of stress or tragedy does not in and of itself ensure isolation and increased mental health problems, but the response we have to tragedy can become a self-fulfilling prophecy or an opportunity for growth.

The scientific literature on behavioral interventions to promote social connections (at all ages) is limited. The authors of this paper collaborate in a laboratory at the University of Rochester, called the HOPE Lab (Helping Older People Engage), focused on developing and testing the most effective strategies to promote social connections in later life. We are all also active clinicians with older adults. Although current evidence-based options for promoting social connections are lacking for older adults, there are evidence-informed strategies, best practices, and approaches we have found promising in our research studies and clinical work, and we share them here in the hope that they may be useful to the readers of *AJGP* and their patients in this time of uncertainty and social distancing. We begin by presenting clinical considerations and actionable items based on what is known about social connectedness in older adults. We then provide a conceptual model that is designed to be used by clinicians and shared with patients and can be used to structure a brief single-session (30 minute) intervention (with optional follow-up) to develop a “Connections Plan” for coping with social isolation,

then illustrate its application with three case examples from our ongoing studies.

Creating a “Connections Plan” is similar to creating a Safety Plan to help patients manage suicide risk²⁵—it is often used in the early sessions of psychotherapy to support safety and may evolve throughout treatment, but can also be used as a standalone intervention in certain settings, such as when Safety Planning is used in emergency departments.²⁶ Indeed, tips for creating Safety Plans with older adults may be useful when creating a Connections Plan and we refer readers to a paper our group published for guidance.²⁷ A Connections Plan is similarly flexible and can be adapted to meet various service settings. We provide case examples in settings where a Connections Plan can be easily integrated into ongoing behavioral health treatment—outpatient clinics and a long-term care setting—but a Connections Plan could be implemented in other settings. Finally, we end with our reflections on how we can increase our collective understanding of the important public health problem of social isolation during this global pandemic.

CLINICAL CONSIDERATIONS

Social disconnection in later life is due in part to objective circumstances—increasing disability and frailty, environmental barriers to socialization, and bereavement,^{28–30} as well as subjective perceptions, such as thinking of oneself as useless or always alone.^{31–33} All forms of social connections are important to health, including “superficial” social interactions such as a brief conversation in a grocery check-out line. However, which aspects of social connectedness are most essential for health and well-being vary across people and within people depending on time and situation. It is important not to make assumptions about the types of social interactions or social relationships that are most meaningful or important to an older person. It is also important to keep in mind that many of us do not give direct thought to these types of questions on a regular basis, and thus older adults may need time to think about what is most important and meaningful to them. One older adult might value positive, brief conversations with a neighbor, while another finds meaning and purpose in a volunteer position, and another finds comfort and solace in deep family relationships.

Social connectedness is an “umbrella term”² that encompasses many different aspects of social relationships. Three forms of connectedness are especially salient for helping older adults during COVID-19.³⁴ Social isolation refers to characteristics of social ties and networks that are insufficient, such as infrequent visits or calls with family or friends. Second, social support involves the functions that relationships provide, including information, instrumental support (e.g., assistance with activities of daily living), and emotional support. The third domain is the psychological experience of feeling isolated or connected (e.g., loneliness, belonging). All three domains are included in a 17-item questionnaire designed for use with older adults during the COVID-19 pandemic—the Questionnaire for Assessing the impact of the COVID-19 Pandemic on Older Adults³⁴ (available for free at <https://www.qiacpoa.com>). Several items assess social isolation during the pandemic, including “how has the frequency of your communication with close friends and family changed” and “how are you continuing to stay in touch with others?” Social support is also assessed, both emotional (“who is providing you with social support?”) and instrumental (“How much difficulty do you have obtaining the food that you need or medicine or medical care because of the COVID-19 pandemic or social distancing rules?”) The questionnaire also includes the three-item UCLA Loneliness Scale to assess that domain of connectedness.³⁵

Barriers to social connectedness are varied, dynamic, and inter-related. Thus, diagnosing the problem is the most essential and challenging part of treating social isolation. The most effective response is one that targets an individual’s specific circumstances and employs straightforward, actionable information to improve social health. The Questionnaire for Assessing the impact of the COVID-19 Pandemic on Older Adults may be useful in conceptualizing patients’ barriers to connectedness, though initiating the conversation with open-ended questions that use broad terms (e.g., relationships) is often useful because terms such as loneliness carry stigma. A nuanced and thoughtful assessment is the most powerful tool in an intervention for social connectedness. While almost any type of increased behavioral activation may reduce depressed mood, any type of increased social activity will not necessarily reduce isolation and loneliness—the intervention must target the cause.

FIGURE 1. A cognitive-behavioral model of social isolation.



In [Figure 1](#), we provide a cognitive-behavioral model of social connectedness that can be explained to patients in just a few minutes and can be used to create a “Connections Plan,” similar to a Safety Plan for suicide risk, that includes coping strategies for managing or preventing social isolation during the COVID-19 pandemic (or any time social isolation is salient for a patient) via a telephone visit. The simple act of discussing social isolation as something that matters for health and that is within a patient’s control is of therapeutic value in and of itself. Self-efficacy and hope are powerful motivators of health behavior change.

Making a simple recommendation about possible new ways to connect with others may work for some older adults, but likely will not work for many. How we learn to engage with others is often shaped by our familial, cultural, and generational roots. For many older adults who lived the majority of their lives in communities that provided naturally occurring opportunities for social connection, including social clubs, veterans’ organizations, churches, and workplace-sponsored activities, the idea of being intentional about social connection is foreign. In addition, there are many emotional barriers to changing our social behaviors that make maintaining the status quo

much more comfortable and less effortful even though isolation and loneliness are painful. It is helpful to identify any factors that may be contributing to reluctance through a question such as, “What do you think you might lose by making new friends or participating in new activities?” Or “What might be hard about using your Connections Plan?” “When you think about [calling X hotline, etc.] what emotion do you feel?”

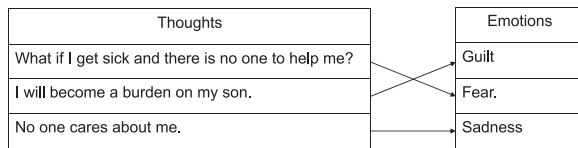
A COGNITIVE-BEHAVIORAL MODEL OF SOCIAL ISOLATION

Similar to depression and anxiety, loneliness and stress related to social isolation can be conceptualized as being caused and maintained not just by “objective” circumstances, but also by our thoughts, behaviors, and feelings surrounding those experiences. Thus, teaching an older patient to understand his or her experience of loneliness or isolation through the cognitive-behavioral lens can foster a sense of agency and control as well as identify tailored intervention strategies to reduce distress.

When educating patients about how perspectives of a stressful event like social distancing can impact our emotional and behavioral responses to it, clinicians must be careful not to invalidate an older patient’s experience by seeming to “blame” their stress on their perspective. Rather, clinicians should explain that our perspective—and how we think about our experience—is one aspect of a stressful situation over which we have control. To illustrate the relationship between thoughts and feelings (compare, the “cognitive model”), clinicians may wish to use examples that are not from the patient’s own life experience, particularly if this is the first time the patient is learning this concept. Emotionally laden experiences can complicate learning the concept that “thoughts can cause feelings” because patients focus on the content of the thoughts rather than the process of how thoughts in general influence feelings. To teach this concept in the context of social isolation, clinicians could use an exercise such as is depicted in [Figure 2](#), which includes a “matching exercise” whereby patients and clinicians can discuss how different interpretations of being alone in one’s home due to social distancing can be associated with different thoughts and therefore different emotional

FIGURE 2. Matching exercise to teach the cognitive model for social isolation.

Matching exercise to teach the cognitive model for social isolation.



reactions. The implication for patients, of course, is that we all have the power to “talk back to thoughts” in order to change our emotional experience. [Table 1](#) includes three basic cognitive strategies clinicians can use to help patients challenge thoughts that may exacerbate loneliness and increase distress. There are three questions patients can ask themselves to identify possible negative and unhelpful thoughts and ways to challenge (or “talk back to”) those thoughts; some of these strategies are adapted from the strategies to address “negativity bias” in psychotherapy for depression in later life³⁶ and we have adapted them successfully for use with isolated and lonely older adults.

[Table 1](#) also lists another strategy to change thoughts or perspectives—mindfulness-based meditation, which some research has demonstrated may reduce loneliness in older adults.³⁷ In fact, a mobile-health delivered mindfulness training program has also been shown to reduce loneliness and increase social activities among adults reporting above average stress.³⁸ This m-health study suggested that orientation to the present moment (versus rumination about the past or worry about the future) with mindful acceptance was the mechanism that accounted for reduced loneliness and increased daily social contact. Mindfulness training programs commonly teach participants emotion regulation skills—the process by which individuals are aware of, understand, accept, and successfully modify the experience and expression of their emotions.³⁹ Mindfulness training does this by teaching people to use their attention to approach their thoughts and emotions, rather than avoid them, and to do so with acceptance rather than shame or anger.⁴⁰ Emerging evidence suggests that mindfulness training can also improve interpersonal processes, including social communication, relationship satisfaction, and

compassion toward others.^{41,42} Compassion, meaning to suffer together, is a multidimensional process of bringing awareness to suffering, with intention to respond to and relieve the suffering, and can be directed toward the self and others.⁴³ Another meditative practice known as loving-kindness, a concept akin to benevolence and goodwill, is a series of exercises designed to cultivate and enhance kindness and compassion toward the self and others. Research on loving-kindness supports evidence of increased positive emotions,⁴⁴ less psychological distress,⁴⁵ and increased social connectedness.⁴⁶ Therefore, introducing patients to mindfulness and loving-kindness training during social distancing restrictions may improve emotion regulation and social functioning among older adults by reducing distress surrounding social isolation and thereby promoting more adaptive coping. During a crisis such as the COVID-19 pandemic, these practices acknowledge a shared suffering that may relieve loneliness and enhance belonging.

In addition to being an emotionally distressing state in itself, loneliness is associated with other negative emotional states, such as anxiety. As with other forms of late life anxiety, therefore, addressing physiologic manifestations directly can be a useful strategy for managing distress associated with loneliness and isolation. Thus, clinicians are encouraged to teach patients strategies used for anxiety management, such as relaxation, soothing with the five senses, and altering body chemistry through cold or warm sensations ([Table 1](#)). Distress tolerance skills from Dialectical Behavior Therapy (DBT) may be useful for some patients and [Table 1](#) contains a link to download a free workbook for using DBT skills to manage uncertainty during COVID-19.

Addressing loneliness and isolation can also be achieved by changing one’s behaviors and actions, and creative solutions are needed to maintain social connections during times of social distancing practices. Some patients may initially resist such strategies because they are frightened or ashamed (or many other emotional responses). Open-ended, leading questions that help patients identify potential strategies themselves (rather than offering advice) can increase motivation. The case examples below illustrate ways to engage older patients in a brief problem solving exercise to identify new ways they can connect with others in meaningful ways even when they

*Strategies to Promote Social Connections Among Older Adults***TABLE 1. Cognitive-Behavioral Strategies (and resources) for Managing Social Isolation**

Change Your Perspective		
Use these three prompts to change your perspective and use helpful self-talk: 1) How can I view the situation from a different perspective? 2) Think of someone optimistic whose opinion you highly value: how would they perceive the situation? 3) Remind yourself: Don't believe everything you think!	Engage in a mindfulness activity or prayer to connect with a sense of our shared humanity and that we are all in this together. Resources: • Headspace app: (including loving-kindness meditation): http://headspace.com • Tara Brach, PhD, Guided Meditation: https://www.tarabrach.com/meditation-times-of-pandemic/	Examine the evidence: write down your thought (e.g., no one cares about me) and list the evidence in support of that thought and the evidence that contradicts that thought.
Change Your Body Sensations		
Practice noticing and tolerating feelings and body sensations instead of resisting them and pushing them away. Resources: Download the free pdf for "Tolerance for Uncertainty: A COVID-19 Workbook" (Dr. Sachiko Nagasawa): https://www.baypsychology.ca/workshops	Soothe your body and mind: • Create pleasant sensations for your five senses: music, good smells, pet your dog/cat, look at art, sip tea. • Calming activities: progressive muscle relaxation and guided imagery exercises.	Change your temperature: • Warm-up: take a warm bath, hold warm towels (right out of the dryer), or sip warm tea. • Cool down: splash your face with cold water or hold a cold pack (or ice cube).
Change Your Body Sensations		
Change your actions—new ways to connect Help others: write emails or letters and take care of pets. Resources: • AARP's Connect2Affect website offers additional ideas and resources for connecting during the COVID-19 pandemic: https://connect2affect.org/coronavirus/ • GeroCentral is a clearinghouse of resources for clinicians and older adults and families that includes links to virtual activities: https://gerocentral.org/clinical-toolbox/covid-19-resources/	Connect with people in safe ways: provide (or receive) phone/video calls and remind yourself of good memories (e.g., photographs); call warm-lines for support. Resources: • The Institute on Aging's 24-hour toll-free Friendship Line: 1-800-971-0016 • The Society for Post-Acute & Long-Term Care Medicine: See tip sheets for facilities to mitigate the emotional impact of social distancing protocols: https://paltc.org/COVID-19	Do things that remind yourself of your connection with nature, a higher power, or our shared humanity: get fresh air, make art, listen to music, watch birds and look at flowers. Resources: • American Health Care Association/ National Center for Assisted Living: See <i>Tips for Keeping Residents Engaged</i> : www.ahcancal.org/coronavirus • Read stories of care and watch video messages of hope for residents and staff, or upload your own message to be shared on social media: www.carenotcovid.com

must maintain physical distance, including using technology to connect with friends or family, helping others (e.g., writing letters), and taking actions to remind themselves of a greater connection and purpose. Each of these CBT strategies is illustrated below in the three case examples.

Clinicians working with patients to create a Connections Plan via phone may wish to mail or email copies of the patient handouts ahead of time (Table 1, Figs. 1–3). If that is not possible, the clinician may need to move more slowly through the material and more frequently ask the patient to repeat back what they heard to demonstrate understanding. Clinicians using videoconferencing can share their screen to

show patients the handouts and also email them so patients can follow along.

CASE EXAMPLES

Case Example: Mr. X, Who Lives Alone at Home

Mr. X is a 74-year-old widowed man who lives alone in an apartment. He finds it difficult to get around physically due to a past hip fracture, and cannot drive himself because of deterioration in his vision. The only people with whom he has regular contact are fellow congregants at his church which is

FIGURE 3. Worksheet for developing a Connections Plan.

Worksheet for developing a Connections Plan.

My Connections Plan

1. Ways I can change my perspective:
 1. _____
 2. _____
 3. _____
2. Ways I can change how my body feels:
 1. _____
 2. _____
 3. _____
3. Ways I can connect:
 1. _____
 2. _____
 3. _____

several miles away and a neighbor in the apartment downstairs who has two children, who Mr. X enjoys playing with from time to time. Mr. X is not in contact with any of his family, as he had a falling out with his siblings years ago. Mr. X usually takes an Uber or taxi to church twice a week for services and Bible study. Since the outbreak of COVID-19, Mr. X's church is no longer a gathering place, opting instead to post video services. Mr. X is unable to take public transportation or Uber or taxi anywhere, as he is concerned about catching the virus. Finally, because of the disruption in his neighbor's schedule caused by school closures, working from home, and social-distancing recommendations, Mr. X's neighbor is having difficulty finding time and ways to visit safely. Mr. X reports feeling lonely and isolated, and is worried he is becoming depressed. Because he feels he has little to do throughout the week, he reports having difficulty distracting himself from negative thoughts and frustration.

As a clinician, the goal of assessment is to determine what is causing Mr. X's feelings of loneliness and isolation, what he values socially, what barriers exist that make it difficult to find new ways to connect. During assessment, the clinician working with Mr. X asked what he enjoys most about his time at church and with his neighbors, and what has changed since the outbreak. From this, the clinician learned that Mr. X and his wife were never able to have children, which they both regretted, and spending time

with his neighbor's children brought him joy; with COVID-19, he thinks that he is being "forgotten" by his neighbors and that he "never really mattered to them anyway." He also values feeling like a part of a community and having a sense of purpose at his church, where he frequently volunteers as an usher. He reports feeling "useless" when he is "stuck" in his apartment without being able to serve at his church. He also reports feeling anxious about how long the situation will last, and states that he sometimes worries the stress is too much for him when he starts feeling sweaty and his heart begins to race. When asked what he sees as the most difficult barriers to staying connected socially, Mr. X reported that 1) the lack of transportation, 2) lack of social events due to social distancing, and 3) not wanting to bother others too much during a confusing time are the primary barriers.

Mr. X's clinician uses the cognitive-behavioral model outlined in Figure 1 to conceptualize Mr. X's case. He identifies the ways in which Mr. X currently appears to be engaging in negative thinking or self-talk, ways in which Mr. X might benefit from physical changes, and areas in which Mr. X might be able to change his actions to increase social connectedness. He goes through the model and completes a "Connections Plan" (Fig. 3) in collaboration with Mr. X. To address *thoughts* of being "useless," that he is being "forgotten," that he does not "matter" and his concerns about bothering others, Mr. X identifies more neutral or positive perspectives, such as "My neighbors have not forgotten me. They would appreciate spending time with me, but circumstances out of their control make it difficult to visit." To address *physical feelings* of anxiety, Mr. X uses deep breathing and positive imagery. When he finds he feels anxious, he takes five deep breaths and imagines he is in his childhood home, which is a positive memory for him. Finally, Mr. X identifies *actions* he can take to connect more. After sharing that his wife was always the one who called to arrange outings with their friends, he decides to call other members of his church who he knows also live alone once weekly to check in on them. He also makes a plan to call his neighbor to learn how to set up video calls, realizing that his neighbor may be too busy, but that the children have time to teach him. Upon follow-up 2 weeks later, Mr. X reports that he feels more confident after learning to change his perspective and reduce his physical

Strategies to Promote Social Connections Among Older Adults

anxiety, and that confidence helped to increase his motivation and successfully make his calls. His neighbor reported feeling relieved that Mr. X would spend time reading his children stories on video calls and Mr. X reported feeling pleased that he could do something to help. He reports improved mood, states that he no longer feels quite so lonely, and jokes that his wife would be shocked by his new behaviors.

Case Example 2: Mr. Y Who Lives in a Nursing Home

Mr. Y is a 77-year-old, Caucasian, male who was admitted to a nursing home 6 months ago for long-term care due to frequent falls and a decline in his ability to manage his activities of daily livings at home. He has multiple chronic conditions, including diabetes, heart disease, dementia, and depression. His wife of 45 years still resides in their home and would visit several times a week before the pandemic. His children and grandchildren would also call regularly and visit occasionally. He misses the reassuring presence of his family, but when they visit it reminds him of all the activities they can no longer do together because of his illnesses and disability. When his family is not visiting, Mr. Y spends much of his time watching TV in his room or sleeping. Despite encouragement from family and staff, Mr. Y avoids socializing with other residents or engaging in recreational activities in the nursing home. Recently he is having more difficulty following conversations over the phone and remembering what he wants to say, which makes it harder to connect with loved ones. He is concerned that his dementia is progressing and he longs to return home and spend his days walking his dog, playing with his grandchildren, and going out to eat with his wife. When COVID-19 spreads to a nearby community, a social distancing protocol is put in place at the nursing facility where Mr. Y lives. The protocol includes restrictions on outside visitors, activities outside of the facility, and group activities within the facility. His family attempts to mitigate the impact of the restrictions by calling more frequently, but Mr. Y refuses to take their calls. He starts having difficulty sleeping at night and appears more restless and irritable during the day, sometimes yelling at staff and other residents. Mr. Y did not use the term “lonely” to describe his experience, but his thoughts, feelings, and actions demonstrate how loneliness and

social isolation may present in long-term care settings. Despite frequent calls from family, Mr. Y’s *thoughts* focused on his loss of emotional connection with loved ones and concerns of further loss due to cognitive decline. He experienced *feelings* of disconnection, anxiety, and depression. His *behaviors* included avoidance of social and recreational activities, which increased his social isolation and reinforced his feelings of disconnection. In the context of social distancing due to COVID-19, Mr. Y began to experience heightened social isolation and anxiety that manifested in behavioral problems.

To help Mr. Y address his social needs and concerns, a collaborative process was used to develop a “Connections Plan” that would be feasible within the current restrictions and additional responsibilities placed on healthcare staff due to COVID-19 protocols. Mr. Y’s clinician described the CBT model of loneliness and social isolation (Fig. 1) to the treatment team and then to Mr. Y and his wife, and together they developed a modified version of the “Connections Plan” in Figure 3. The plan was modified to emphasize behavioral strategies (i.e., behavioral activation) over cognitive strategies (i.e., cognitive restructuring), which may be beneficial for individuals with cognitive impairment. Mr. Y initially had difficulty identifying social activities that were meaningful for him, so the recreation therapist met with Mr. Y individually to engage in reminiscence around themes of work, leisure, and friends or family to clarify what was important to him in his social relationships. The social worker gathered additional information about recent changes in his relationships and amount of social activities from his wife. To address Mr. Y’s resistance to phone calls, the recreation therapist asked him what was hard about talking on the phone and what most concerned him. Through this collaborative process, three activities were identified and integrated into his daily schedule.

To facilitate ongoing *connections* with family, daily video calls were scheduled to occur at the same time each day with his wife and other family members. A device with videoconferencing capability was provided for these calls to reduce some of the barriers he encountered when using the phone. To address Mr. Y’s worry (*thoughts*) that he couldn’t remember important information that he wanted to share with family, the recreation therapist began meeting with him individually to create a scrapbook of family

memories. They also created a poster that visually represented important things that Mr. Y wanted others to know about him that could be hung in his room to cue personally meaningful conversations with staff and other residents. To reduce *physical feelings* of anxiety, Mr. Y's clinician taught him a simple, brief relaxation breathing exercise that staff could cue him to practice several times a day. For all residents, staff communicated a simple, clear message of reassurance that the community was working to ensure resident safety. The treatment team monitored Mr. Y's behavior and adherence to the plan over the next month to track his progress and make adjustments to the plan as needed.

Case Example 3: Ms. Z, a Spanish-Speaking Woman Who Lives Alone

Ms. Z is a 66-year-old Spanish-speaking woman who lives alone. She was born and lived in Puerto Rico but relocated in 2017 to the U.S. mainland to live near her daughter and grandchildren in the wake of Hurricane Maria. Ms. Z relies on her daughter for transportation and as her English interpreter. Although integrating into her new town has been difficult due to language barriers, she enjoys watching her grandchildren on the weekends and joining the family for dinner regularly. She also started to attend a senior center for Spanish-speaking older adults run by a local community agency. Ms. Z was particularly looking forward to an extended trip back to Puerto Rico this spring, after having to delay the trip due to damaging earthquakes in Puerto Rico earlier in the year. However, she had to cancel the trip following the outbreak of COVID-19. The senior center meetings have been cancelled as well, and her daughter has encouraged Ms. Z to stay at home, preferring she no longer watches the children. Although her daughter brings her anything she needs, Ms. Z reports feeling increasingly anxious and isolated. She feels worried for her family in Puerto Rico and feels trapped in her own home.

As with previous examples, a clinical assessment should seek to understand the causes of Ms. Z's feelings of isolation, her social values, and barriers to meeting those values. During the assessment, Ms. Z's clinician asks what she values most about her time with her family and at the senior center, and barriers to those since the outbreak. Ms. Z indicates that she feels useful when she takes care of her grandchildren

and enjoys cooking traditional meals and teaching them about their roots over dinner. She feels that now, however, she is becoming a "burden" instead, as her daughter must take care of her and the kids too. The senior center used to help her feel connected to her culture as well and provided a place for her to get support from others with similar experiences. Now she feels she has no one to talk to and is anxious about all the rapid changes. The most difficult barriers for Ms. Z in staying connected are: 1) lack of information (partially due to language barriers), 2) lack of activities with others who speak Spanish (due to social distancing), and 3) not wanting to be a burden.

Using the cognitive-behavioral model, Ms. Z's clinician helps her form a "Connections Plan" (Fig. 3) to change her self-talk, body sensations, and actions to promote connection. Ms. Z notes her *negative self-talk* includes, "I am a burden" and "I can't handle another disaster" and identifies more helpful thoughts such as: "My family wants to take care of me because they love and need me," and "We have made it through difficult times before." To address *physical feelings* of anxiety, Ms. Z listens to her favorite music from her childhood which makes her feel calm and safe. Finally, Ms. Z identifies *actions* to increase connection. She plans regular calls with other members from the senior center and her family in Puerto Rico. She also video chats with her daughter every morning over coffee, during which her daughter updates her on news and Ms. Z shares cooking advice and recipe ideas. She also starts calling her grandchildren at night and telling them bedtime stories. At follow-up, Ms. Z reports that although she still feels lonely and worried at times, she has things to look forward to and does not get stuck in those emotions. She reports she no longer feels like a burden either because multiple people, including her grandchildren, have commented how much her calls help them too.

DISCUSSION AND FUTURE DIRECTIONS

Older age and medical comorbidity are factors associated with more severe illness and risk of death due to COVID-19 infection. Social distancing is an important public health strategy for controlling the spread of the virus and minimizing its impact on the older adult population. It comes at a cost, however. Loneliness is associated with myriad adverse health outcomes, one

Strategies to Promote Social Connections Among Older Adults

of which is impaired immune functioning, which adds even greater risk for coronavirus infection, complications and death. Older adults, therefore, are at compound risk, making effective management of loneliness and social isolation in our older patients a high priority target for preventive intervention. Mental health clinicians with the skills to deliver the cognitive-behavioral treatments to older adults described here should be active members of multidisciplinary teams mobilized to manage the COVID-19 pandemic and limit its impact on the older population.

Around the country, mental health clinics are forced to convert from face-to-face models of care to virtual ones. We are accustomed to seeing patients in distress, but never have we all been affected and distressed by the same experience, as with the COVID-19 pandemic. Utilizing the cognitive-behavioral framework for social connectedness presented in this paper and developing “Connections Plans” provides clinicians with evidence-informed lessons gleaned from studies conducted by the HOPE Lab. Most clinicians are not taught ways to reach out to people virtually and are unfamiliar with using only verbal communication to express ourselves and offer comfort. While clinicians may feel uncomfortable with this approach to providing psychotherapy, it is also true that older adults report high satisfaction with psychotherapy provided by telephone and demonstrate high retention rates.⁴⁷ Creating a Connections Plan may help clinicians new to providing psychotherapy remotely because it is feasible and easy to implement over the phone, taking techniques that we already utilize, but putting them together in a straight-forward way that all clinicians can implement. For important issues to consider and practical guidance related to providing telephone psychotherapy, we refer readers to papers by Brenes et al.⁴⁷ and Mozer et al.⁴⁸ Another useful resource is a guide to implementing Safety Planning with older adults, which includes tips for motivating patients and managing issues such as vision impairment and cognitive impairment when creating a Safety Plan, which is a similar strategy to a Connections Plan.^{27,49}

The cognitive-behavioral framework for social connectedness as presented here illustrates effective applications of patient-centered care by mental health clinicians highlighting the importance of knowing patient values and preferences. In times of “social distancing” access to healthcare professionals is also

limited which, in turn, limits opportunities for practicing the skills and reinforcing the patient’s adherence to the “Connections Plan.” Expanding support for the patient’s plan, as described in the case examples which enlisted family involvement, would increase the likelihood of successful implementation. In addition, teaching family members the principles of the cognitive-behavioral model would similarly empower them to comfort and reassure the patient during times of distress. For patients with limited family support and who may have been isolated prior to COVID-19, clinicians will have fewer resources to draw upon when creating a Connections Plan. In those instances, clinicians may need to emphasize distress tolerance strategies and helping the patient find ways of feeling safe and comforted without other people. The title, “Connections Plan” allows for many types of connections—with people, animals, nature, a higher purpose—and all of those connections have value. The importance of connections with people who are not close family and friends—“weak or peripheral ties” in the social network—should not be discounted, as these connections are strongly linked with more positive mood in older adults.⁵⁰ Waving to neighbors, writing letters to individuals in nursing homes, or signing up for an intergenerational pen pal program, can be powerful ways to connect and improve mood. For older adults residing in nursing homes, clinicians can emphasize opportunities for connections with staff during daily care routines.

We hope that the cognitive-behavioral strategies describe in this paper to help patients maintain social connections also provide clinicians with reassurance and hope that isolation and loneliness can be addressed, even during the COVID-19 pandemic. In the HOPE Lab, we regularly discuss the interplay between belonging and hope. This statement from Mother Teresa is on our wall: “If we have no peace, it is because we have forgotten that we belong to each other.” It is our hope that this time of stress and distance will also be an opportunity to identify the most effective approaches to promoting connectedness in later life.

AUTHORS CONTRIBUTIONS

All authors contributed to the conception of the paper, drafting the paper, revising it, and approving it for publication.

The authors report no conflicts with any product mentioned or concept discussed in this article. All authors have provided ICJME Disclosure forms.

This work was supported in part by the following grants: T32MH020061 from NIMH (Conwell, PI);

KL2TR001999 from NCATS (Zand, PI); P30AG064103 from NIA (Heffner & Van Orden, MPI). The views expressed in this manuscript are those of the authors only.

References

- Charles ST, Carstensen LL: Social and emotional aging. *Annu Rev Psychol* 2010; 61:383–409;doi:10.1146/annurev.psych.093008.100448
- Holt-Lunstad J, Robles TF, Sbarra DA: Advancing social connection as a public health priority in the United States. *Am Psychol* 2017; 72:517–530;doi:10.1037/amp0000103, PMC5598785
- Cacioppo JT, Hawkley LC, Thisted RA: Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging, and Social Relations Study. *Psychol Aging* 2010; 25:453–463; doi:10.1037/a0017216, 2010-11857-019 [pii]
- Golden J, Conroy RM, Bruce I, et al: Loneliness, social support networks, mood and wellbeing in community-dwelling elderly. *Int J Geriatr Psychiatry* 2009; 24:694–700;doi:10.1002/gps.2181
- Hawkley LC, Thisted RA, Cacioppo JT: Loneliness predicts reduced physical activity: cross-sectional & longitudinal analyses. *Health Psychol* 2009; 28:354–363;doi:10.1037/a0014400, 2791498
- Whisman MA: Loneliness and the metabolic syndrome in a population-based sample of middle-aged and older adults. *Health Psychol* 2010; 29:550–554;doi:10.1037/a0020760
- Shankar A, McMunn A, Banks J, et al: Loneliness, social isolation, and behavioral and biological health indicators in older adults. *Health Psychol* 2011; 30:377–385;doi:10.1037/a0022826
- Stephens A, Shankar A, Demakakos P, et al: Social isolation, loneliness, and all-cause mortality in older men and women. *PNAS* 2013; 110:5797–5801;doi:10.1073/pnas.1219686110, 3625264
- Hawkley LC, Thisted RA, Masi CM, et al: Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. *Psychol Aging* 2010; 25:132–141; doi:10.1037/a0017805, 2841310
- Hawkley LC, Preacher KJ, Cacioppo JT: Loneliness impairs daytime functioning but not sleep duration. *Health Psychol* 2010; 29:124–129;doi:10.1037/a0018646, 2841303
- Holwerda TJ, Deeg DJ, Beekman A, et al: Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL). *J Neurol Neurosurg Psychiatry* 2012;doi:10.1136/jnnp-2012-302755, Online first
- Waern M, Rubenowitz E, Wilhelmson K: Predictors of suicide in the old elderly. *Gerontology* 2003; 49:328–334
- Luo Y, Hawkley LC, Waite LJ, et al: Loneliness, health, and mortality in old age: a national longitudinal study. *Soc Sci Med* 2012; 74:907–914;doi:10.1016/j.socscimed.2011.11.028, 3303190
- Jaremka LM, Andridge RR, Fagundes CP, et al: Pain, depression, and fatigue: loneliness as a longitudinal risk factor. *Health Psychol* 2014; 33:948–957;doi:10.1037/a0034012, PMC3992976
- 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; 10:227–237;doi:10.1177/1745691614568352
- Durkheim E: *Le Suicide: Etude de Sociologie*. Paris: F. Alcan, 1897
- Joiner TE, Hollar D, Van Orden K: On Buckeyes, Gators, Super Bowl Sunday, and the Miracle on Ice: "pulling together" is associated with lower suicide rates. *J Soc Clin Psychol* 2006; 25:179–195
- Van Orden KA, Witte TK, James LM, et al: Suicidal ideation in college students varies across semesters: the mediating role of belongingness. *Suicide Life Threat Behav* 2008; 38:427–435
- Biller OA: Suicide related to the assassination of President John F. Kennedy. *Suicide Life Threat Behav* 1977; 7:40–44
- Claassen CA, Carmody T, Stewart SM, et al: Effect of 11 September 2001 terrorist attacks in the USA on suicide in areas surrounding the crash sites. *Br J Psychiatry* 2010; 196:359–364; doi:10.1192/bjp.bp.109.071928
- Vuorio A, Laukkala T, Junttila I, et al: Aircraft-assisted pilot suicides in the general aviation increased for one-year period after 11 September 2001 attack in the United States. *Int J Environ Res Public Health* 2018; 15;doi:10.3390/ijerph15112525, PMC6266333
- Medenwald D: Effect of 9/11 on suicide: appropriateness of a time series model. *Br J Psychiatry* 2013; 202:467–468;doi:10.1192/bjp.202.6.467
- Chan SM, Chiu FK, Lam CW, et al: Elderly suicide and the 2003 SARS epidemic in Hong Kong. *Int J Geriatr Psychiatry* 2006; 21:113–118;doi:10.1002/gps.1432
- Yip PS, Cheung YT, Chau PH, et al: The impact of epidemic outbreak: the case of severe acute respiratory syndrome (SARS) and suicide among older adults in Hong Kong. *Crisis* 2010; 31:86–92; doi:10.1027/0227-5910/a000015
- Stanley B, Brown GK: Safety planning intervention: a brief intervention to mitigate suicide risk. *Cogn Behav Pract* 2012; 19:256–264;doi:10.1016/j.cbpra.2011.01.001
- Stanley B, Brown GK, Brenner LA, et al: Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry* 2018; 75:894–900;doi:10.1001/jamapsychiatry.2018.1776, PMC6142908
- Conti EC, Jahn DR, Simons KV, et al: Safety planning to manage suicide risk with older adults: case examples and recommendations. *Clin Gerontol* 2020; 43:104–109;doi:10.1080/07317115.2019.1611685, PMC6858938
- Cohen-Mansfield J, Hazan H, Lerman Y, et al: Correlates and predictors of loneliness in older-adults: a review of quantitative results informed by qualitative insights. *Int Psychogeriatr* 2015; 1–20;doi:10.1017/S1041610215001532
- Hoogendijk EO, Suanet B, Dent E, et al: Adverse effects of frailty on social functioning in older adults: results from the longitudinal aging study amsterdam. *Maturitas* 2016; 83:45–50;doi:10.1016/j.maturitas.2015.09.002
- Theeke LA: Sociodemographic and health-related risks for loneliness and outcome differences by loneliness status in a sample of U.S. older adults. *Res Gerontol Nurs* 2010; 3:113–125; doi:10.3928/19404921-20091103-99
- Aartsen M, Jylha M: Onset of loneliness in older adults: results of a 28 year prospective study. *Eur J Ageing* 2011; 8:31–38; doi:10.1007/s10433-011-0175-7, PMC3047676
- Qualter P, Vanhalst J, Harris R, et al: Loneliness across the life span. *Perspect Psychol Sci* 2015; 10:250–264;doi:10.1177/1745691615568999

Strategies to Promote Social Connections Among Older Adults

33. Cacioppo JT, Cacioppo S, Boomsma DI: Evolutionary mechanisms for loneliness. *Cogn Emot* 2014; 28:3-21;doi:[10.1080/02699931.2013.837379](https://doi.org/10.1080/02699931.2013.837379), PMC3855545
34. Cawthon P, Orwoll E, Ensrud K, et al: Assessing the impact of the covid-19 pandemic and accompanying mitigation efforts on older adults. *J Gerontol: Ser A* 2020;doi:[10.1093/gerona/glaa099](https://doi.org/10.1093/gerona/glaa099)
35. Hughes ME, Waite LJ, Hawkley LC, et al: A short scale for measuring loneliness in large surveys: results from two population-based studies. *Res Aging* 2004; 26:655-672;doi:[10.1177/0164027504268574](https://doi.org/10.1177/0164027504268574), 2394670
36. Alexopoulos GS, Raue PJ, Kiosses DN, et al: Comparing engage with PST in late-life major depression: a preliminary report. *Am J Geriatr Psychiatry* 2014;doi:[10.1016/j.jagp.2014.06.008](https://doi.org/10.1016/j.jagp.2014.06.008)
37. Creswell JD, Irwin MR, Burklund LJ, et al: Mindfulness-based stress reduction training reduces loneliness and pro-inflammatory gene expression in older adults: a small randomized controlled trial. *Brain Behav Immun* 2012; 26:1095-1101
38. Lindsay EK, Young S, Brown KW, et al: Mindfulness training reduces loneliness and increases social contact in a randomized controlled trial. *Proc Natl Acad Sci* 2019; 116:3488-3493
39. Gross JJ, Thompson RA: *Emotion Regulation: Conceptual Foundations*. 2007
40. Vujanovic AA, Youngwirth NE, Johnson KA, et al: Mindfulness-based acceptance and posttraumatic stress symptoms among trauma-exposed adults without axis I psychopathology. *J Anxiety Disord* 2009; 23:297-303
41. Berry DR, Cairo AH, Goodman RJ, et al: Mindfulness increases prosocial responses toward ostracized strangers through empathic concern. *J Exp Psychol: Gen* 2018; 147:93
42. Carson JW, Carson KM, Gil KM, et al: Mindfulness-based relationship enhancement. *Behav Therapy* 2004; 35:471-494
43. Jazaieri H, Jinpa GT, McGonigal K, et al: Enhancing compassion: a randomized controlled trial of a compassion cultivation training program. *J Happiness Stud* 2013; 14:1113-1126
44. Fredrickson BL, Cohn MA, Coffey KA, et al: Open hearts build lives: positive emotions, induced through loving-kindness meditation, build consequential personal resources. *J Pers Soc Psychol* 2008; 95:1045-1062;doi:[10.1037/a0013262](https://doi.org/10.1037/a0013262), PMC3156028
45. Carson JW, Keefe FJ, Lynch TR, et al: Loving-kindness meditation for chronic low back pain: results from a pilot trial. *J Holist Nurs* 2005; 23:287-304;doi:[10.1177/0898010105277651](https://doi.org/10.1177/0898010105277651)
46. Hutcherson CA, Seppala EM, Gross JJ: Loving-kindness meditation increases social connectedness. *Emotion* 2008; 8:720-724; doi:[10.1037/a0013237](https://doi.org/10.1037/a0013237)
47. Brenes GA, Ingram CW, Danhauer SC: Benefits and challenges of conducting psychotherapy by telephone. *Profes Psychol Res Pract* 2011; 42:543-549;doi:[10.1037/a0026135](https://doi.org/10.1037/a0026135), PMC3256923
48. Mozer E, Franklin B, Rose J: Psychotherapeutic intervention by telephone. *Clin Interv Aging* 2008; 3:391-396;doi:[10.2147/cia.s950](https://doi.org/10.2147/cia.s950), PMC2546483
49. Conti E, Arnsperger C, Kraus-Schuman C, et al: Collaborative Safety Planning for Older Adults. Available at: https://www.mirecc.va.gov/VISN16/docs/Safety_Planning_for_Older_Adults_Manual.pdf. Published 2016. Accessed March 15, 2020
50. Fingerman KL, Huo M, Charles ST, et al: Variety is the spice of late life: social integration and daily activity. *J Gerontol: Ser B* 2019;doi:[10.1093/geronb/gbz007](https://doi.org/10.1093/geronb/gbz007)