SOCIAL WELLBEING AGENCY | TOI HAU TĀNGATA

Working Paper

Short Report: Social Isolation, loneliness and COVID-19

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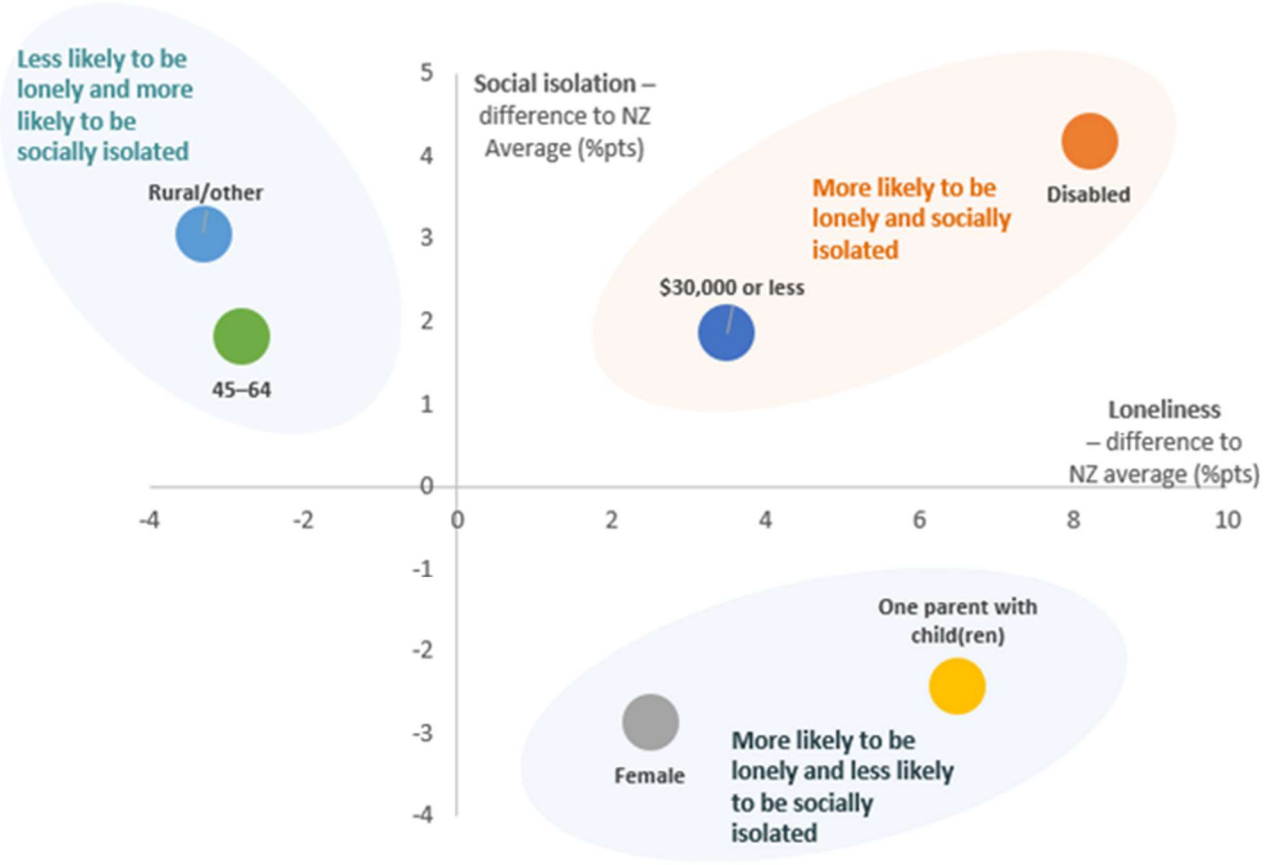
Key Messages

- The COVID-19 pandemic will likely increase social isolation and loneliness, and increase inequalities in these outcomes.
- Social isolation and loneliness are different things, but they are both associated with poor health and wellbeing.
- Being isolated or feeling lonely in childhood can have an enduring influence on health and wellbeing.
- Access to digital connections have become crucial for maintaining social connection and accessing wellbeing resources, but not everyone has access.

Social connection

Social connection is a core psychological need. People need to feel they belong to a group and generally feel close to other people. Our drive to connect with others is embedded in our biology and evolutionary history. Depriving people of social connections has profound impacts on their health and wellbeing. There are two aspects of social connection considered in this report: social isolation and loneliness. **Social isolation** refers to the amount of social contact you have in terms of the number and frequency of contacts, whereas **loneliness** is something we feel when our social relationships are of lower quantity and *quality* than we would like. We all have different levels of need for social contact. You can feel lonely even when you have regular contact with family and friends, and you can be isolated (having few contacts and not seeing them frequently) without feeling lonely. Some people experience both. While isolation is not a requirement for feeling lonely, being socially isolated does increase the likelihood of being lonely, and especially so for older people.

Figure 1: Social Isolation and loneliness GSS 2018 analysis visualisation



Note: This is a visualisation of descriptive analyses to highlight variations in isolation and loneliness. This may not reflect statistically significant differences between population sub-groups

We investigated social isolation and loneliness using the 2018 General Social Survey – a nationally representative sample of ~8000 people. We ran a simple descriptive analysis to inform this short report.

Social isolation was determined by frequency of face-to-face and other contact with family and friends. Loneliness was determined by asking people if they felt lonely at least some of the time in the past 4 weeks.

There was variation in reports of loneliness and isolation, as shown by the graph on above. Some groups reported higher social isolation but lower loneliness (rural residents and 45-64yr olds), and some were more likely to report feeling lonely but reported lower isolation (sole parents, females). Other groups report both higher social isolation and loneliness (disabled, and those in low income households).

Loneliness and isolation impact wellbeing

There is consistent evidence for a relationship between loneliness, health and wellbeing. Loneliness is associated with poorer physical health (strong evidence for cardiovascular health and mortality), mental health (particularly anxiety and depression, but also self-harm and suicide), and a lower quality of life[1,2,3]. The available evidence indicates social isolation and loneliness are both associated with poor health[4]. Understanding relationships between social isolation, loneliness and health is complicated. It can be difficult to unpick whether poor health leads to isolation and/or loneliness, or whether isolation and/or loneliness lead to poor health, or both.

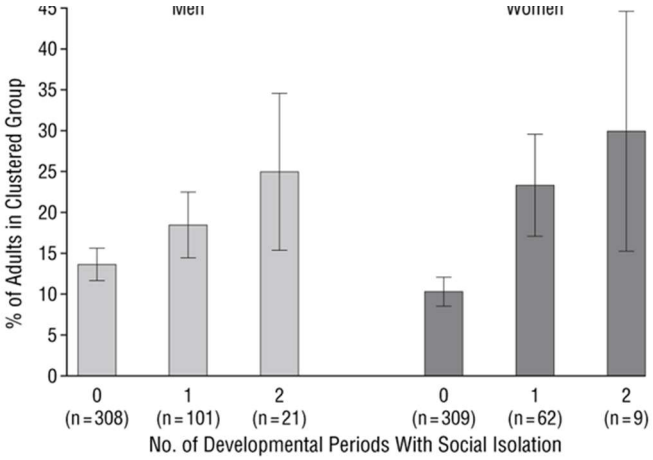
Following the same people over time is one way to try and untangle this knot.

Evidence from the Dunedin study, a New Zealand study that has followed 1037 children from birth, shows a dose-response relationship between social isolation at multiple life stages (childhood, adolescence and young adulthood) and cardiovascular health risks at age 26.

As shown by the graph to the right – the percentage of adults with 3+ risk factors for cardiovascular disease increases with a greater exposure to social isolation across development periods.

Other longitudinal studies find a similar pattern for blood pressure, mortality and cognitive decline. Being lonely at a single point in time is still associated with increased health risks, but these are exacerbated if an individual is lonely for a longer period.

Figure 2: Association between cumulative social isolation and risk-factor clustering (3+ risks) for cardiovascular disease in adulthood



From: Socially Isolated Children 20 Years Later: Risk of Cardiovascular Disease. Arch Pediatr Adolesc Med. 2006;160(8):805-811. doi:10.1001/archpedi.160.8.805

For illustrative purposes, study participants were considered isolated if they were in the top decile in each developmental period. Limit lines indicate standard error.

More direct attempts have been made to determine the direction of the association between loneliness and depression. One study considered whether loneliness at the start of the study (baseline) increased subsequent depressive symptoms, and whether depressive symptoms at baseline predicted subsequent loneliness – a reciprocal relationship was found[5]. Another study found that experiencing loneliness in the previous year predicted depression but experiencing depression in a previous year did not predict subsequent loneliness[6]. However, it is possible that the effects of depression on loneliness take more than one year to manifest.

Even though many lonely children do not become lonely adults, evidence from the Dunedin study, as well as similar studies internationally, point to an enduring effect of being isolated or lonely in childhood on adult mental and physical health[7,8,9.] In childhood our most important relationships are with our caregivers, and in adolescence peer relationships become increasingly important. Where these relationships are dysfunctional, children feel lonely and this can lead to health-damaging behaviours (such as smoking, excessive drinking, poor diet), psychological distress, and poorer educational attainment and lower subsequent earnings as children become adults. All of these increase the likelihood of poor adult health.

Who are the most likely to feel lonely and be isolated?

Our descriptive analysis of the 2018 General Social Survey coupled with a literature review suggests that the following groups of people were most at risk of feeling lonely and socially isolated in NZ, prior to the COVID-19 pandemic.

Lonely	Socially Isolated
Adults who live alone, or do not live with family/partner	Unemployed
People who have a disability	People who have a disability
Young people (aged 15-30)	Migrants
Single parents	Those residing in rural areas
People in low income households	People identifying as Asian
People who live in deprived areas	People in older age groups (65+)
People identifying as Māori or Asian	People residing in rural areas

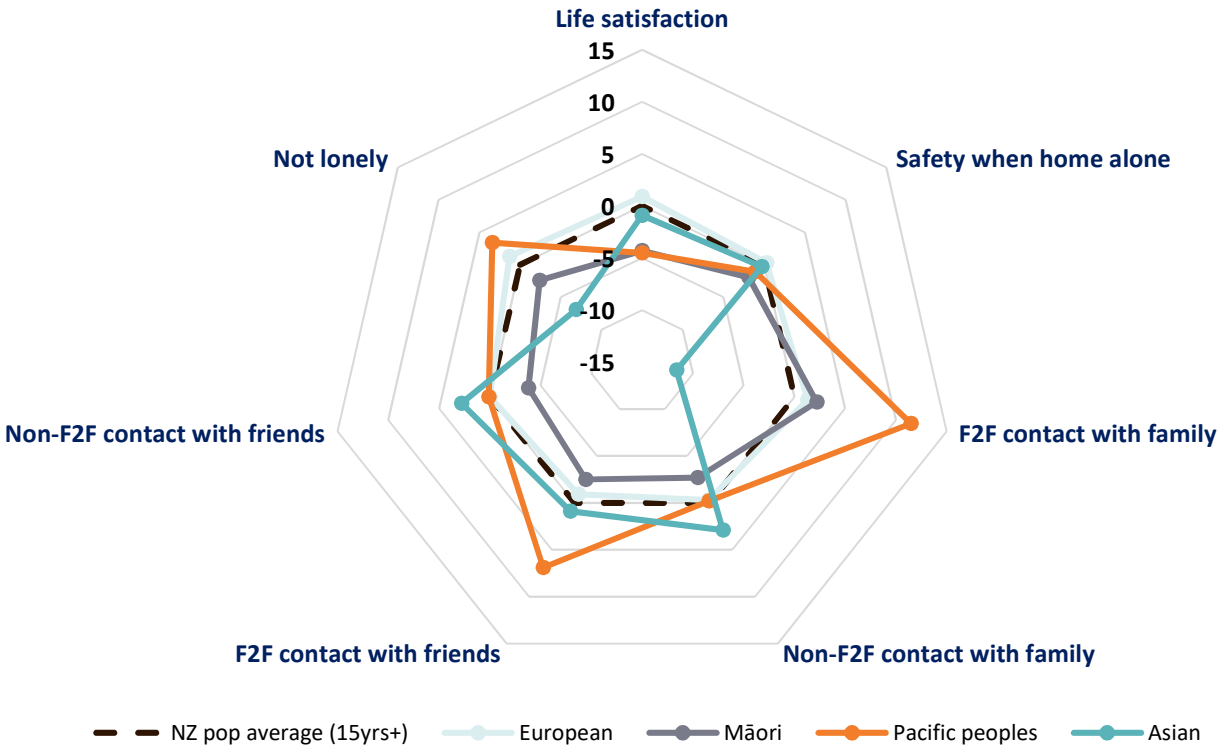
The high level of loneliness among young people (15-30) is a consistent finding internationally[10]. Reported loneliness tracks downwards as age increases and then rises slightly from age 75+. Explanations for this focus on young adulthood being a time of many significant life transitions such as moving away from home, starting university and/or work, and entering parenthood[11,12]. Social isolation is more likely to be experienced by older age groups due to increased likelihood of living alone, relocation, losing friends and loved ones, and inability to participate in activities due to access issues, mobility, illness or transport[13,14,15]. Furthermore, social networks for those aged 65+ are more likely to consist solely of family members. Our descriptive analysis also highlighted those aged 45-65 as being more isolated, due to a lower frequency of contact with family and friends than other age groups.

Younger children (aged 10-12) report experiencing loneliness more often than older children (13-15)[12]. Children residing in deprived households, with less satisfying relationships with family and friends, or who had a limiting longstanding illness or disability were most likely to report feeling lonely often. In childhood our most important relationships are with our caregivers. Children and adolescents who experience abuse or neglect, who are in care or are leaving care, or those who are young carers – especially for parents with mental health issues - are at risk of feeling lonely and isolated[16].

That loneliness is more likely to be experienced by those who reside in deprived areas is partially due to the characteristics of these areas, such as higher levels of residential mobility, lower perceived safety, and lower access to community spaces[17]. It can also be due to a higher percentage of people experiencing financial hardship living in deprived areas. Having the means to socialise is important because there is often a cost for social participation, and people on low incomes may not have the resources to participate.

Our descriptive analysis of the 2018 General Social Survey and literature review indicate that rates of loneliness and social isolation differ across ethnic groups. This can be seen in the spider diagram below. Reported loneliness is highest among those identifying as Māori or Asian. Reasons for this may be linked to differential expectations of family support, experienced racism, differential health status and socioeconomic circumstances. A higher proportion of Asian participants are also likely to be (recent) migrants. Pacific peoples report lower levels of loneliness coupled with comparatively high levels of face to face contact with friends and family

Figure 3: GSS 2018 reported loneliness and social isolation indicators by ethnicity



Note: The Loneliness values have been inverted and the label changed to 'Not lonely', for ease of interpretation. Groups with values inside the black circle (NZ population average) are more likely to be struggling, groups with values outside the black circle are less likely to be struggling. This is a visualisation of descriptive analyses to highlight variations in isolation and loneliness. This may not reflect statistically significant differences between population sub-groups

What this means for COVID-19

The COVID-19 pandemic and subsequent restrictions on physical distancing are likely to increase social isolation and loneliness. In terms of mitigating the impact on health there are two takeaways from the available evidence:

1) We should focus on reducing **sustained** feelings of loneliness and promoting belongingness[18], and
2) That focussing on just one aspect: loneliness or isolation, is unlikely to be beneficial - we should focus on both[4]. Efforts to improve health by simply increasing social contact may not mitigate loneliness and associated health risks. Equally, providing people with better ways to cope with and manage feelings of loneliness may not mitigate health risks of those who remain socially isolated.

The COVID-19 pandemic will likely exacerbate inequalities in loneliness and social isolation.

- Access to the internet has become crucial for social connection during lockdown by allowing social connection with physical distance. Many of the resources/tools developed to improve mental wellbeing and encourage social connection in response to the COVID-19 lockdown rely on having access to the internet and are often designed with smartphone or tablet users in mind. Evidence from the COVID-19 Justice sector survey (week of 12th-20th April) which took place during the level 4 lockdown demonstrates this point - overall 4% of respondents reported feeling lonely all or most of the time, but 14% of those with no access to the internet felt lonely all or most of the time. The 2018 census estimates that around 86% of New Zealand households have access to the internet, but one person households, single parent and low-income households are less likely to have internet access[19] - all of which are groups with higher reported loneliness.
- The sudden loss of our usual routines could put many of us at risk of feeling lonely. Across the socioeconomic spectrum, job loss and uncertainty of income could lead to increasing social isolation and feelings of loneliness over time. However, having savings and assets, access to high speed internet and entertainment subscription packages, as well as living in warm, dry and uncrowded housing will make it easier to cope with and manage these feelings. Therefore, those in more precarious financial situations may be more vulnerable to loneliness and isolation affecting their health.

The evidence also highlights the important and enduring effect of caregiver-child and adolescent-peer relationships on feeling lonely in childhood/adolescence, and subsequent adult outcomes. The COVID-19 lockdown and economic downturn to follow will put strain on these relationships.

- It is likely that children will experience and observe more violence. There was a spike in reported instances of family violence at the start of the lockdown period in NZ, and while police data suggest this dropped to 'usual levels' within a couple of weeks, it is unclear if this reflects reality[20]. The increasing stress and anxiety caused by the lockdown restrictions, job and/or income loss, and economic uncertainty will increase the likelihood that children experience abuse at home, and they will not have easy access to adults outside of the home to talk to or to report suspected abuse.
- UNICEF also warn that spending more time on virtual platforms during COVID-19 lockdown can leave children and adolescents vulnerable to online sexual exploitation, as predators look to take advantage of the COVID-19 pandemic[21]. For adolescents, a lack of face-to-face contact with friends and partners may lead to heightened risk-taking such as sending sexualised images, while increased and unstructured time online may expose children to potentially harmful and violent content, as well as greater risk of cyberbullying.

Contact

For more information on the analysis or review underlying this report, contact the Insights team at: Insights@SWA.govt.nz

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