



A conceptual review of loneliness across the adult life course (16+ years)

Synthesis of qualitative studies

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Summary

We know that loneliness has negative impacts on how we feel about ourselves and people around us and it can have harmful effects on our physical and mental health. Yet loneliness is a complicated subject. Loneliness is conceptually and empirically distinct from social isolation, and to a range of deep and sometimes long-last negative feelings. Sometimes it is viewed more positively in terms of solitude and a chance to escape from the pressures of life. It is often difficult for people to talk about loneliness and it is reported in different ways by researchers, policy makers and practitioners. This review is needed because the evidence on loneliness is scattered and tends to be focused on single population groups, and most often considers older people only. There is a lack of clarity about definitions of loneliness and related concepts, and how they should be evaluated, measured and applied in policy and practice. The review topic was agreed with organisations who work on the national policy for loneliness in the UK, as well as those who manage, deliver and research it.

This review wanted to identify and address differences in the language used in undertaking research, making decisions and developing practice about loneliness because the way we talk about loneliness influences decisions about how best to alleviate loneliness across peoples' lives.

We looked at studies published worldwide since 1945 and found 144 qualitative sources conceptualising loneliness across the adult life course. In these studies, three types of loneliness were identified: social loneliness, emotional loneliness and existential loneliness. Social loneliness refers to the perceived deficit in the quality of social connections. Social loneliness was conceptualised in studies of young people, paid and unpaid work, healthcare, place, migrant and cultural groups, and older people and health and social, communities, health and illness, rural and urban environments, and migrant, cultural and gender groups. Emotional loneliness refers to feelings which arise from loss of meaningful relationships that meet a deeply felt need to be recognised and belong. Studies reporting on emotional loneliness across the life course included work on loss of a spouse, physical and mental health conditions, family contexts and place. Existential loneliness refers to an experience of feeling entirely separate from other people, often when confronted with traumatic experiences or mortality. Studies including people with mental illness, older population groups and in psychotherapy described existential loneliness.

There is an extensive body of qualitative literature which conceptualises loneliness across the adult life course. We can have high confidence that loneliness can be conceptualised as social loneliness and moderate confidence that loneliness can be conceived as emotional loneliness and existential loneliness. There is an opportunity to build better evidence about how loneliness makes people feel and about the relationship between loneliness and wider social inequality.

Executive Summary

Introduction

The protocol for this review was registered on the PROSPERO International Prospective Register of Systematic Reviews (Registration number CRD42019124565 Available from: https://www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=124565)

The review sought to address the question 'how is loneliness conceptualised across the adult life course (16+ years) in reported research findings?'

Review approach

The review included empirical research that evaluated loneliness using any study design and published 1945 to December 2018. Grey literature in the form of evaluation reports (no date restriction) were included. Included studies needed to have employed an identified theory, model, concept or framework for understanding loneliness, however conceptualised. Only qualitative studies met the inclusion criteria and we report on those.

Results

After duplicates were removed, the electronic searches returned 5117 published records for screening. 144 qualitative studies conceptualising loneliness across the adult life course (16+ years) were included.

Characteristics of included studies (qualitative)

This review reports on 144 qualitative studies in total. Included in the published sources are 108 qualitative studies and qualitative evidence from thirteen mixed methods studies, seven book chapters and sixteen unpublished reports. The unpublished reports are project evaluations reporting qualitative data and doctoral dissertations. The included studies evaluated and conceptualised loneliness for diverse population groups across the life course and in different settings.

The review includes qualitative evidence variously collected from interviews, observation, document analysis, diaries, and focus group methods. Evidence is interpreted and synthesised to identify and discuss conceptualisations of loneliness. Limitations in the qualitative studies included limited discussion of recruitment strategies, insufficiently rigorous data analysis, and inadequate discussion of relationships between participants and researcher and a lack of detail regarding ethical issues.

The review includes published and unpublished reports from more than 4608 participants from 27 countries including the USA, England, Ireland, Scotland, Sweden, Australia, Italy, Canada, Denmark, New Zealand, Belgium, Norway, Finland, Iran, Mexico, South Africa, the Netherlands, Nepal, Turkey, China Hong Kong, Poland, Nigeria, Japan, Israel, Chile, Malaysia and Lithuania.

Summary of study findings

144 qualitative studies examined conceptualisations of loneliness. Loneliness was defined in the included studies by three types; social loneliness (n=103), emotional loneliness (n=24) and existential loneliness (n=17). Studies emphasised one of these three types of loneliness and some considered the interconnections between two or more different types. We define these types of loneliness in the report and synthesise the evidence on them. The included studies conceptualised loneliness in different ways and for diverse populations groups including old people, young people, groups specified by cultural, gender and sexual-orientation, people living with physical and mental illness, homeless people and prisoners. Studies were conducted in several contexts including in healthcare, education establishments, workplaces, sports and community locations.

We can have high confidence that loneliness can be conceptualised as social loneliness and can be used to enhance understanding of loneliness across the adult life course. The review reports a judgment of moderate confidence that loneliness can be conceived as emotional loneliness and existential loneliness due to minor concerns with relevance, and moderate concerns with methodological limitations, coherence and adequacy. Most published studies obtained appropriate ethics approval, although this was not always reported extensively. Methodological weaknesses of these qualitative studies included a lack of exact details of the researcher's role, potential bias and influence on sample recruitment, setting and responses of participants. Grey literature was of mixed quality with high quality reports including details of methodological approach, theoretical analysis and recognition of limitations and low quality (credibility) reports providing little detail of methods and commonly taking participant accounts at face value without theoretical analysis.

Strengths and limitations of the review

The focus on concepts, models, theories and frameworks of loneliness and the challenges in searching for this type of evidence means that it is possible that some relevant evidence is not included. However, we undertook a comprehensive search strategy to identify all existing eligible studies published for the search dates. We also made provision for a second stage rapid review on themes identified in stage one. The pre-publication of our protocol on PROSPERO ensures methodological transparency and mitigates against potential post-hoc decision-making which can introduce bias to the process. Dual screening of searches and data extraction and independent quality assessment using CERQual criteria ensured a rigorous process.

Taking published studies as the sole evidence increases the potential risk of publication lag wherein possible important new evidence that has not yet been included in published reports is not identified and included. The grey literature review allowed recent unpublished data from evaluations completed (no date specification) to be included.

The use of the CERQual criteria introduces an element of subjective judgement. A consistent approach to judgments across the different concepts has been applied, and more than one reviewer was involved in making decisions while recognising that these judgments are open to interpretation.

Implications for research policy and practice

1. The conceptualisation of social loneliness, emotional loneliness and existential loneliness reported in this review reflects established theoretical frameworks for understanding loneliness and can be recommended for decision making in policy and practice.
2. The evaluation of the findings in this review of moderate confidence in the evidence for emotional and existential types of loneliness largely relates to methodological issues in the conduct of the research. There is, therefore, considerable potential to generate a more robust evidence base for policy and practice, especially for prevention and intervention development and evaluation.
3. There is an extensive body of qualitative research conceptualising predominantly social loneliness across the adult life course. This understates the significance of emotional and existential loneliness. Therefore, there is scope in research, policy and practice to explore in more detail the different types of loneliness and their interrelationships to understand who feels lonely, when where and in what contexts. This suggests a need to evaluate the way loneliness is conceptualised in our commonly used measurement tools. This will offer an evidence-based foundation for developing policy and practice and developing more tailored interventions.
4. Most studies focus on older people and we would recommend studies which focus on a wider range of age groups in different social contexts and/or which adopt an identified life course perspective
5. There is a dearth of studies focusing on loneliness in young people and we would recommend studies which focus on this population group.
6. A more sophisticated approach to understanding loneliness in the life course should recognise issues of transition and change and examine how experiences are influenced by specific socio-cultural and personal influences which have an impact on subsequent life trajectory.
7. A more sophisticated approach to understanding conceptualisations of loneliness and key theoretically informed issues including identity (e.g. gender, ethnicity, disability, socio-economic status), trauma or survivorship and stigma.
8. The extensive qualitative literature conceptualising loneliness is mainly reported separately from quantitative studies. We would recommend high quality mixed methods study designs that employ rigorous and systematic quantitative methods, longitudinal process evaluations and cost effectiveness evaluations.
9. Research, policy and practice approaches to loneliness can be enhanced through coproduction methods involving mutually beneficial working practices in service design, implementation and evaluation.

Introduction

Background

This conceptual review of loneliness reflects work developed from a previous overview of systematic reviews on loneliness interventions (Victor et al., 2018) and focused outputs on loneliness measures from the What Works Centre for Wellbeing (<https://whatworkswellbeing.org/product/brief-guide-to-measuring-loneliness/>). It supports current UK policy and practice prioritisation for understanding loneliness as a factor that compromises wellbeing and implementing and evaluating interventions to alleviate loneliness across the adult life course (<https://www.gov.uk/government/publications/a-connected-society-a-strategy-for-tackling-loneliness>). It has been produced with stakeholder engagement with key UK Government Departments, local and regional public health experts and community groups. This review is needed because the full body of evidence on loneliness is scattered across different disciplines, located variously, tends to be focused on one domain such as loneliness or social isolation in single population groups, and most often considers older people only. There is a lack of clarity about definitions of loneliness and related concepts, and how they should be evaluated, measured and applied in policy and practice (Windle et al. 2011, Courtin and Knapp 2015; Victor et al., 2018).

Since an initial study of older people in 1948, loneliness has been largely seen as a problem of old age (Sheldon, 1948). As with the concept of wellbeing, loneliness is debated and contested. Some philosophers argue that loneliness is a universal human experience (Rotenberg, 1999; Mijuskovic, 1981). Most of us will encounter loneliness at some point in our lives either as momentary feeling or a more protracted experience. In public health, loneliness has been problematised because of the associations with a range of negative health outcomes including mortality, morbidity, health behaviours and 'excess' service use (Victor, Scambler and Bond, 2008). Furthermore, loneliness has been proposed as a homogeneous, static and/or linear experience, that it is quantitatively accessible (i.e. we can measure it) and that there is 'something' that we can and should do to prevent or cure it (Russell, Peplau and Cutrona, 1980).

Terms and terminology are especially important when undertaking research, setting policy agendas and developing practice in the field of loneliness. Related concepts such as living alone, or isolation are often inaccurately used as synonyms for loneliness. Social isolation is focused upon the size of an individual's social network. Isolation may be defined broadly as having few and infrequent social ties. Living alone describes an individual's household composition. Both living alone, and isolation are objective quantifiable constructs. This differs from loneliness which is the outcome of an individual's subjective evaluation of their social relationships as not meeting their expectations. Conceptually and empirically, loneliness, isolation and living alone are distinct but related concepts and are not linguistically, empirically or conceptually interchangeable. When interpreting and using evidence about loneliness these conceptual challenges are important to identify and address because they will have a profound influence on the generation and interpretation and potential impact of evidence on policy, practice and research in the field.

The systematic review assessed all relevant evidence on conceptualisations of loneliness across the adult life course (16+ years). This report is a synthesis of included qualitative studies.

The protocol for this review was registered on the PROSPERO International Prospective Register of Systematic Reviews (Registration number CRD42019124565 available from: https://www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=124565).

Research question

How is loneliness conceptualised across the adult life course (16+ years) in reported research findings?

Methodology

Overall review strategy – A two-stage method

Following a review of methods for conceptual reviews and discussion with evidence review experts, we employed a two-stage method based on Walsh et al., (2017). A stage one review process identified evidence on conceptualisations, models, frameworks and theories of loneliness and related concepts or domains. Provision for a stage two process to conduct appropriate additional reviews of evidence for the concepts and theories identified in stage one was made. To date a stage two search strategy has not been necessary due to the extensive evidence included in this review. This method provided a rigorous systematic approach to presenting a detailed evidence-based conceptual map of loneliness across the life course.

Following a review of evidence on search strategies for qualitative, quantitative, mixed methods and conceptual literature (see for example Booth and Carroll, 2015; Cooke et al., 2012; Erikson and Frandsen, 2018; Walsh et al., 2017), we used an adapted search strategy identified as PEEST (Participants, Exposure, Evaluation, Study Design, Theory) to identify relevant literature for inclusion.

Types of participants

The review included participants across the adult life course (16+ years) recruited to studies evaluating and conceptualising loneliness. The evidence includes work with clinical populations, those living in community settings, older people, young people, employees, migrants, widows, parents, homeless people, volunteers, teachers, prisoners, and victims of domestic violence, victims of natural disasters, business leaders, caregivers, golfers, students, veterans, and those in palliative care. Our protocol was to include studies from countries economically like the UK (i.e. other high-income countries with similar economic systems and in the same group as the UK in the OECD Development Assistance Committee categories) or with study populations that have similar socioeconomic status to the UK. Therefore, there are included studies from a wider range of countries and these studies include theoretical and conceptual approaches to loneliness that inform our review. Countries in which the studies are based are listed in the table of included studies (Table 4 Supplementary Material).

Exposure - Loneliness

To be included, studies needed to have evaluated experiences of loneliness, however conceptualised, in any setting.

Evaluation

Included studies must have evaluated loneliness outcomes or processes or both.

Study design

We included published studies that evaluated loneliness using any study design and published post 1945 to December 2018. We included empirical research: quantitative, qualitative or mixed methods. Included studies needed to have employed an identified theory, model, concept or framework for

understanding loneliness, however conceptualised and beyond a simple definition or background literature review. We identified relevant systematic reviews published for the purposes of hand searching the reference lists. We hand searched the reference list of systematic reviews published 1945-2018. Grey literature (no date restrictions) was also included. This report synthesises studies eligible for inclusion in this review all of which were qualitative.

Type of theory

Included studies needed to have employed an identified theory, model, framework or concept for understanding loneliness, however conceptualised.

Search methods for identification of reviews

Electronic searches

Electronic databases were searched using a combination of controlled vocabulary (MeSH) and free text terms. Search terms were incorporated to target studies examining models, theories and frameworks of loneliness. The search strategy was informed by expert consultation with policy makers, practitioners and researchers familiar with this field of study. The example search strategy can be found below. All database searches were based on this strategy but will be appropriately revised to suit the precise requirements for searching. The following databases were searched from 1945 (or the earliest date of records) to the present:

- Scopus
- Medline (via Ovid)
- Eric (via EBSCO)
- PsycINFO (via EBSCO)
- CINAHL Plus
- Arts and Humanities Citation Index (Web of Science)
- Social Science Citation Index (Web of Science)
- Science Citation Index (Web of Science)

Demonstration search strategy

An example Ovid Medline search strategy is shown below:

1. Lonel*
2. "Social Isolation"
3. (1 or 2) AND (4 or 5 or 6 or 7)
4. Model*
5. Framework
6. Concept*
7. Theory

Searching other sources

The reference lists of all relevant reviews since 1945 were hand-searched to attempt to identify additional relevant empirical evidence. A search of 'grey literature' was conducted via an online call for evidence, employment of expert input, review of key sector websites and a Google search (key word search and reviewing titles of first 100 hits). Grey literature (no date restriction) was included if it

was an evaluation or report on empirical data, had the evaluation of loneliness as the central objective, included a model, theory or framework for understanding loneliness, however, conceptualised and included details of authors (individuals, groups or organisations).

Identification of studies for inclusion

Search results were independently checked by two review authors. Initially the titles and abstracts of identified studies were reviewed. If it was clear from the title and abstract that the study did not meet the inclusion criteria it was excluded. Where it was not clear from the title and abstract whether a study was relevant the full article was checked to confirm its eligibility. The selection / eligibility or inclusion criteria were independently applied to the full papers of identified reviews by two review authors. Eligibility criteria are summarised in Table 1. Where two independent reviewers did not agree in their primary judgments they discussed the conflict and attempted to reach a consensus. If they could not agree then a third member of the review team considered the title and a majority decision was made. Studies in any language were included. A table of excluded studies can be found in Supplementary Material - Appendix 2.

Table 1 Eligibility criteria

PEEST criteria	Inclusion	Exclusion
Participants	<ul style="list-style-type: none"> ▪ Any population group 16+ years ▪ Studies from countries economically like the UK (i.e. other high-income countries with similar economic systems) or with study populations that have similar socioeconomic status to UK. 	<ul style="list-style-type: none"> ▪ Participants not meeting age criteria (i.e. <16 years)
Exposure	<ul style="list-style-type: none"> ▪ Loneliness, however conceptualised in any setting 	
Evaluation	<ul style="list-style-type: none"> ▪ Loneliness outcomes, processes or both ▪ Presentation of model, concept or Framework for loneliness. 	
Study Design	<ul style="list-style-type: none"> ▪ Empirical research: either quantitative, qualitative, or mixed methods, outcomes, or process evaluations ▪ Grey literature: final evaluation or report on empirical data, evaluation of loneliness as the central objective, presents model, concept, framework for understanding loneliness and includes details of authors (individuals, groups, or organisations) ▪ Studies published between 1945-2018 ▪ Grey literature published since 1945 	
Type of Theory	<ul style="list-style-type: none"> ▪ Identify theory, model, framework or concept for loneliness 	<ul style="list-style-type: none"> ▪ Discussion articles, commentaries or opinion pieces not presenting empirical or conceptual research on loneliness ▪ Grey literature if it does not have details of authorship

Data collection and analysis

Data extraction and management (qualitative studies)

For this report, data was extracted independently by a reviewer using a standardised form (Appendix 1) and cross-checked by a second reviewer. Discrepancies were resolved by consensus. The data extraction form included the following details relevant to the qualitative study designs and qualitative elements of mixed methods study designs:

- title, authors and year of publication
- the objectives of the study
- details of the included participants including a focus on protected characteristics and socio-economic status
- definitions of loneliness, and theories, models, concepts or frameworks included
- evaluation and analysis approaches to understanding loneliness including relevant concepts, theories or models and/or analysis of mechanisms and processes associated with loneliness, and ethical considerations
- themes, model, framework and concepts employed and key findings
- study conclusions
- study limitations, gaps and conflicts of interest identified

For grey literature the data extraction included the following details from the PHE framework (Daykin and Joss, 2016):

- project description
- aims and objectives
- evaluation design
- data collection methods
- ethics and consent
- data analysis methods
- costs and budget
- key findings

Our protocol allowed us to contact the authors of articles if the required information could not be extracted from the studies and if this was essential for interpretation of their results. We did not need to follow this procedure.

Assessment of methodological quality of included studies

To assess the methodological quality of the included published studies, two review authors independently applied the CASP quality checklist for qualitative studies as detailed in the What Works Centre for Wellbeing methods guide (Appendix 1). The checklists were used to indicate if a specific study had been well designed, appropriately carried out and properly analysed. A summary of quality scores for published qualitative studies is presented in Table 2 ([see supplementary material](#)).

We then employed the CERQual schema (Confidence in the Evidence of Reviews of Qualitative Research) for judging how much confidence could be placed in the review findings developed through the synthesis.

Four components are used in the CERQual approach to assess confidence in the evidence for individual review findings; methodological limitations, relevance, coherence, and adequacy of data (Lewin et al. 2015). Categories of confidence in CERQual are high, moderate, low and very low. Table

5 identifies the review findings for qualitative research in this report and provides a qualitative evidence profile. Confidence was decreased if there were serious or very serious limitations in design or conduct of the study, evidence was not relevant to the study objectives, findings/conclusions were not supported by the evidence, or data was inferior quality and inadequate in supporting findings. Confidence was increased if the study was well designed with few limitations, evidence was applicable to context (perspective or population, phenomenon of interest, setting) specified in objectives, findings/conclusions were supported by evidence and provided convincing explanation for patterns found, or data supporting findings was rich and high quality.

The PHE Arts for Health and Wellbeing Evaluation Framework (Daykin and Joss, 2016) was used to both extract data from the grey literature and judge the quality of it in terms of the appropriateness of the evaluation design, the rigour of the data collection and analysis and precision of reporting which is reported narratively. A summary of quality ratings for unpublished qualitative studies is presented in Table 3 ([see supplementary material](#)).

Data synthesis

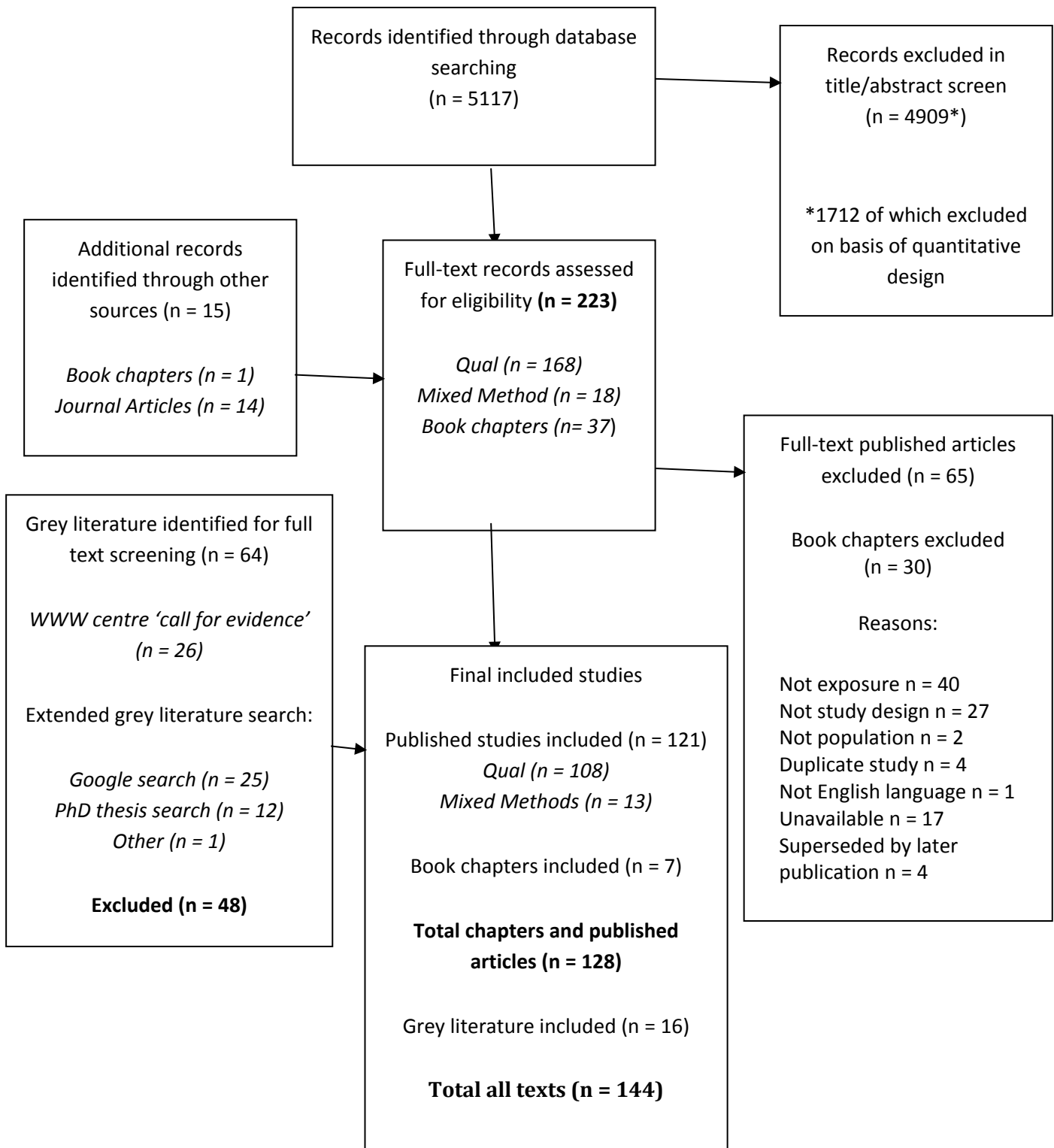
In this report, we present an evidence synthesis of the published and unpublished qualitative data which conceptualises loneliness across the adult life course. The data is synthesised thematically (see for example Braun et al., 2019) to reflect three themes in the evidence base; (i) social loneliness, (ii) emotional loneliness, and (iii) existential loneliness. Synthesis was conducted through the development of a framework of loneliness, which identified the three types of loneliness and was constructed from the evidence in the review (an inductive approach). This framework was drafted by two researchers (ND and LM) and refined by the research team. It was used to code each study in the review to one or more of the types of loneliness. These types of loneliness are the themes identified in the included literature and are developed in the process of synthesis in a broadly inductive way. However, it is impossible to take an approach to the analysis of loneliness in this project that is completely detached from existing theories. Researchers in the project had various levels of knowledge and expertise of existing theoretical approaches to loneliness. We did not come at the synthesis tabula rasa, nor did we impose existing theories on the evidence. The types of loneliness that have resulted from the synthesis reflect existing theory but not in an exact way. We tabulate eligibility criteria, summaries of the characteristics of the included studies and quality judgement and identify and discuss important limitations and gaps within the evidence base.

Results

Results of the searches (published literature)

After removal of duplicates the electronic searches returned 5177 records for screening. Of these, 208 were retained after abstract and title screening and fifteen additional studies were also identified through other sources (hand searching of systematic review reference lists). 223 full texts were assessed for eligibility against the inclusion criteria. The full text screening process identified 144 published studies conceptualising loneliness; 108 qualitative studies (interviews, observation, document analysis, diaries, and focus group methods), the qualitative findings from thirteen mixed methods studies and seven book chapters based on qualitative research. The search screening process is illustrated in Figure 1.

Figure 1: PRISMA flow diagram of the search screening process



Characteristics of included studies (published literature)

The included studies conceptualised loneliness in different ways and for diverse populations groups including old people, young people, groups specified by cultural, gender and sexual-orientation, people living with physical and mental illness, homeless people and prisoners. Studies were conducted in several contexts including in healthcare, education establishments, workplaces, sports and community locations. Loneliness was defined in the included studies by three types; social loneliness, emotional loneliness and existential loneliness. Studies emphasised one of these three types of loneliness and some considered the interconnections between two or more different types. We define these types of loneliness in the report and synthesise the evidence on them.

A summary of the characteristics of the included papers is presented in Table 4 (see 'Supplementary Material') and the references section. The list of excluded studies and reasons for exclusion can be found in Supplementary Material - Appendix 2.

Table 4 Characteristics of included studies conceptualising loneliness (published and unpublished literature)

Due to the high number of included studies represented in the table of included studies, Table 4 can be found in the [supplementary material](#).

Grey literature (unpublished) searches and results

The grey literature search was undertaken concurrently with the conceptual review of loneliness. A call for grey literature evidence evaluating and conceptualising loneliness was advertised between December 2018 and January 2019. The call requested reports on a model, theory or framework for understanding loneliness or a related concept (e.g. social isolation, or social exclusion). Additionally, we conducted an extended systematic search of grey literature by employing expert input that assisted in identifying sources of grey literature that might not be readily available in searching peer-reviewed literature (Benzies et al., 2006). Specifically, we (i) contacted known experts in the field for recommendations of reports on loneliness (ii) reviewed websites of organisations prioritising loneliness in their work (iii) searched the EThOS website for unpublished PhD dissertations and (iv) conducted a Google search with key words: 'loneliness', 'isolation', 'evaluation', 'conceptual', 'report', reviewing titles of the first 100 results.

A total of sixty-four submissions were screened by the research team, of which sixteen met the inclusion criteria. Submissions reviewed for eligibility included 26 received through the call for evidence, and thirty-eight obtained via the extended search for grey literature. Reasons for exclusion were 'not adult population', 'not loneliness focussed' and 'not qualitative methods'. A summary of the grey literature included in this review can be found in the table of included studies (Table 4 [supplementary material](#)).

In the grey literature, conceptualisations of loneliness were described across the life course, for diverse population groups and in different settings. Qualitative interviews were employed in all sixteen grey literature reports as the principle method of data collection. Focus groups, observations and diaries were additionally used in some evaluations [126,128,132,134,135,137,138,139,140]. One report included the use of a music elicitation tool [137] and another employed a document analysis method. [128] One study was defined as a creative and collaborative research project. [126] Analysis frameworks used in the grey literature included thematic approaches and phenomenological and hermeneutic principles.

There were two reports on projects seeking to understand and alleviate loneliness focused on young people. One used a collaborative approach with young people themselves to explore what loneliness means ^[126] and the other examined the role of youth organisations and experienced and expert youth workers in supporting loneliness in youth groups ^[138]. Both provided detailed methods, rich data and in-depth analysis.

Seven grey literature reports focused on understanding loneliness in older population groups in nursing homes, community settings and for those living with mental health conditions or with no cognitive decline. ^[128, 132, 133, 134, 135, 137, 139] A report on a single case of a person (30 years) experiencing anxiety and panic attacks examined the impact of long-term psychotherapy on understanding and alleviating loneliness through the therapeutic relationship. ^[131] The experience of loneliness for parents identified as socially isolated and engaged in a home visiting intervention was reported in one grey literature source. ^[127] In addition, one report detailed the experience of being a married woman who feels alone in a marriage. ^[129]

Three reports in the grey literature examined loneliness across the life course including participants in the age range 17-75 years and with varying demographic profiles. ^[130, 136, 144] One of these reports examined experiences of loneliness for those living with mental health conditions and accessing mental health services ^[130]. Another of these explored the effects of loneliness on consumers' engagement with social media advertising ^[136]. The third of these collected views of loneliness from people experiencing loneliness and experts seeking to address the issue. ^[144] This report revealed adverse impacts of loneliness on health, social contact, feelings of being trapped and alone and associated negative emotions including frustration and anger. This report emphasised loneliness as a key political issue. ^[144] One grey literature report investigated loneliness and social isolation experienced in marginalised population groups in Scotland including women from BAME communities, people living in socio-economically deprived area, in rural communities, paid and unpaid carers of people receiving palliative care. ^[140]

Overview of quality of included studies

The scores for the qualitative studies quality checklists are presented in Table 3 (see [supplementary material](#)). For the qualitative studies the most frequent methodological weaknesses within the studies were limited discussion of recruitment strategies, a lack of rigor in data analysis, no adequate discussion of relationships between participants and researcher and a lack of detail regarding ethical issues. The results of the quality checklist for qualitative studies varied with best scoring (meeting 8 out of 8 criteria) in thirty sources. ^[2,6,10, 19, 20, 23,26,29,34,36, 37,39,43,45, 48, 58, 71,82, 83, 84, 87, 91, 93, 94, 95, 99, 101, 102, 112, 116] and worst scoring (meeting 1 or 2 out of 8 criteria) in 5 sources. ^[18, 21, 61, 64, 122]

The use of the CERQual schema for judging the confidence in the findings from the synthesis of qualitative evidence results in a high confidence rating to the synthesis findings on social loneliness. The evidence in this review on social loneliness is highly relevant for conceptualising loneliness across different stages of the life course and for different population groups in a range of settings and context. A moderate confidence rating was given to the synthesis findings for emotional loneliness and existential loneliness. We can have moderate confidence from the evidence in this review that loneliness can be conceptualised as emotional and existential and that such conceptualisations are relevant for understanding loneliness across the adult life course.

Using the PHE Arts for Health and Wellbeing Evaluation Framework we gave a quality (credibility) rating of high, moderate or low to the grey literature. A summary of the quality assessment for the grey literature can be found in Table 3. Of the sixteen included grey literature reports, evidence from six have high quality (credibility) due to the inclusion of detailed description and theoretical reflection on methods, approach, and limitations, attention to assessment of quality for the qualitative elements,

recognition of limitations and a theoretically informed analysis. Seven reports are rated with moderate quality (credibility) due to the inclusion of a description of the methods and approach but little detail on analysis of data. Three reports were rated with low quality (credibility) as they relied on face value reporting of participants' accounts, lacked identification of limitations and did not include a theoretically informed analysis.

Evidence on conceptualising loneliness - summary and synthesis of findings

Study participants

The review includes published data from more than 4,608 participants in 27 countries- USA, England, Ireland, Scotland, Sweden, Australia, Italy, Canada, Denmark, New Zealand, Belgium, Norway, Finland, Iran, Mexico, South Africa, the Netherlands, Nepal, Turkey, China, Hong Kong, Poland, Nigeria, Japan, Israel, Chile, Malaysia and Lithuania. Many studies did not report participant numbers.

All participants were involved in qualitative research methods. The evidence includes work with clinical populations, those living in community settings, older people, young people, employees, migrants, widows, parents, homeless people, volunteers, teachers, prisoners, and victims of domestic violence, victims of natural disasters, business leaders, caregivers, golfers, students, veterans, and those in palliative. Participants were involved in a range of projects focused on understanding and conceptualising loneliness in diverse ways. Studies included cultural and physical activity interventions, workplace, community and educational programmes, therapy, and person-centred and holistic, system-wide approaches. Where demographic characteristics of participants were reported, this revealed a mix of gender, age, socio-economic and employment status, disability, and ethnic backgrounds.

The review also includes unpublished data from around 278 participants in England, USA, South Africa and Scotland. In this grey literature participants were both male and female. Not all reports stated demographic details.

Loneliness definitions

The following definition of loneliness and related terms are commonly cited in studies included in this review and represent established definitions and theories widely accepted in the literature and research on loneliness. Our review showed that included studies both reflected and developed these established definitions and in particular we identify three types of loneliness from our synthesis methods.

Loneliness

Loneliness is broadly defined as “the unpleasant experience that occurs when a person’s network of social relations is deficient in some important way, either quantitatively or qualitatively” (Perlman and Peplau, 1981, p. 31). Loneliness is a subjective evaluation experienced even if others, significant or not, are present. It is a heterogeneous experience that can be experienced across three distinct but linked dimensions: frequency, duration and intensity. Loneliness can be chronic and long-lasting or fleeting and temporary.

From the synthesis of evidence in this review three main types of loneliness are identified. Emotional loneliness describes the absence of meaningful relationships, often as a result of the loss of a key attachment figure such as in bereavement or through changes in relationships that happen through retirement, domestic abuse, or physical and mental health crises. Social loneliness evaluates the quantity as well as quality of relationships including intimate/romantic relationships. Implicitly or explicitly social loneliness is resultant from deficits in the expectations of social relationships. Existential loneliness is less related to the specifics of relationships but is focused upon a more global

evaluation of disconnection from others and the wider world and is often, but not exclusively, linked to end of life. There are overlaps between these types of loneliness.

The significance of identifying these types of loneliness is twofold: (i) recognising the complexity of loneliness experiences helps to advance knowledge by understanding diverse social, psychological and contextual issues that are connected to loneliness in the lives of people and (ii) different types of loneliness (and associated concepts identified below) need to be evaluated and measured appropriately. Evaluation research will have a profound effect on the generation and interpretation of evidence in decision-making about what interventions work, for whom and in what context. Although beyond the scope of this review we need to critically examine how well existing loneliness measures reflect these differing conceptualisations.

Social isolation

Social isolation is commonly defined as “the state in which the individual or group expresses a need or desire for contact with others but is unable to make that contact” (Carpenito, 1992, p. 731). It is a situation which refers to a quantitatively diminished social network (Victor & Yang, 2012). Social isolation can refer to two distinct concepts: physical separation or restricted social networks. Social isolation can be used to describe those who are physically separated because they live at some distance from others. More typically social isolation refers to a denuded or restricted social network of individuals based upon counting network membership and identifying those who have small networks.

Aloneness

Aloneness is an objective state of having no one around or being by oneself for protracted periods of time (Haber et al. 1987; Hancock, 1986; Victor et al. 2000; Walton et al. 1991). Aloneness may occur not just in single person households but also in communal or larger households where individuals may be left alone while, for example, other household members are at school or work.

Solitude

Solitude is a state of voluntary aloneness, during which personal growth and development and creative activity may take place. Solitude is associated with self-discovery, rest, relaxation and escapism and happiness (Berkowitz, 2009; Morgan, 2016). No distinctions or inferences are made about the duration of the experience or the drivers that underpin the search for solitude.

Positive and negative aspects of loneliness

A central debate evidenced in this review is the difference between positive and negative aspects of loneliness which reflects an established theoretical discussion in the literature and the identification of a need to understand emotional loneliness as a distinct concept but one potentially overlapping with other types of loneliness. While being alone can have positive connotations, loneliness is generally viewed as unpleasant and potentially harmful (Hauge et al. 2010; Martina et al. 2012). Aloneness and solitude are viewed as positive when they are creative, productive and maturing (Karnick, 2005; Long et al. 2003). Negative experiences of loneliness include feelings of sadness, anxiety, fear, deprivation, neglect, abandonment, shame and suffering (Peplau & Perlman, 1982). Loneliness is not the same as depression, but the two conditions are strongly associated, especially in older people (Kharicha et al. 2017).

Loneliness, social isolation and social exclusion

The evidence base includes examples where loneliness and social isolation are used interchangeably. They are in fact different states. Some of the best evidence in this review supports and discusses this point. Social isolation is an objective condition arising from the structure of a person’s social network (Bantry-White et al. 2018; Hemingway et al. 2013). In contrast, loneliness is a subjective experience arising from qualitative and quantitative deficits in a person’s social relationships (Canham, 2015). Social isolation, and social exclusion, or the involuntary exclusion from

geographically and identity-bound communities (LeGrand et al. 2014), may increase the risk of loneliness. However, the frequency of social contacts or increased social networks do not necessarily diminish loneliness: the quality of friendships/relationships and not just the quantity of social connections is important in decreasing vulnerability to loneliness (Ballin & Balandin, 2007).

Theories and themes for conceptualising loneliness

Reflecting Weiss (1973), and Peplau and Perlman (1982) two broad conceptualisations of loneliness; social and emotional, underpin most of the theoretical approaches in the included studies in this review. A third concept of existential loneliness also features in the literature. The framework for synthesising the evidence in this review distinguished the three types of loneliness defined below, which both reflects and develops the existing theoretical understandings of loneliness.

Social loneliness

Social loneliness arises from the absence of social connection, the perception of social isolation and dissatisfaction with the quality of relationships (Adams et al. 2016). It is sometimes explained by a cognitive deficit model, which suggests that loneliness arises from a discrepancy between the actual and desired quantity and quality of interaction with others (Bantry-White et al. 2018; Peplau & Perlman, 1982, Bennett & Victor, 2012). It is also explained as an evaluation of the feeling of satisfaction one has with one's social network (Townsend, 1957)

Emotional loneliness

Emotional loneliness arises from the absence or loss of meaningful relationships that meet a deeply felt need to be recognised and 'belong' to someone (Dong et al. 2011) or to a group such as at work, or in a family. Emotional loneliness is viewed as arising from the loss or absence of a primary non-substitutional attachment figure, such as a spouse (Weiss, 1973, 2007, Bennett & Victor, 2012) or other family member or work/professional person. Emotional loneliness includes distressing feelings such as emptiness and abandonment (Davies et al. 2016; Doblaz et al. 2018).

While social loneliness can be addressed by integrating into a social community, those experiencing emotional loneliness may find it difficult to find satisfying relationships even if they have a network of friends and acquaintances.

Existential loneliness

Existential loneliness is described as a universal aspect of the human condition which expresses the separateness of the person from others (Moustakas, 1961, Cherry et al. 1993, Hauge et al. 2010). While people may experience existential loneliness at any time, people with life threatening illness or those experiencing trauma face heightened experiences because of their confrontations with extreme situations and/or mortality.

Synthesis of qualitative evidence

144 qualitative studies (108 qualitative studies, thirteen mixed methods studies including qualitative data collection and analysis, seven book chapters and sixteen unpublished reports) included in this review focused on conceptualising loneliness. They do so in diverse theoretical ways and using a mixture of qualitative methods (interviews, observations, document analysis, music elicitation, diaries). In synthesising the qualitative evidence, three key findings are identified, which concern the conceptualisation and understanding of loneliness and reflect established theoretical approaches in loneliness research: (i) social loneliness, (ii) emotional loneliness, and (iii) existential loneliness. For each review finding in this synthesis, CERQual has been applied. The Qualitative Evidence Profile is presented in Table 5 and we provide a narrative discussion of the findings and the levels of confidence we can have in them.

Table 5 CERQual qualitative evidence profile

Review findings	Studies contributing to the review finding	Methodological limitations component	Relevance component	Coherence component	Adequacy of data component	Overall CERQual assessment of confidence	Explanation of judgement
Conceptualising and understanding social loneliness (n=103)	1-6, 9-15, 17, 20, 21, 23, 26, 27, 29, 31-42, 44-48, 50-54, 56, 57, 63, 65-67, 69-73, 75, 77, 78, 80, 81, 84, 86, 88-90, 92, 94, 96, 97-105, 107, 108, 110, 111, 113-115, 119-121, 124-130, 133, 135-144.	Minor concerns (5 studies several limitations, 86 studies minor methodological limitations, 19 studies maximum quality, 5 grey literature high, 4 moderate, 3 low)	Minor concerns for relevance (all studies examined social loneliness)	Minor concerns for coherence (data reasonably consistent within studies, low consistency across studies on population and context)	Minor concerns about adequacy (40 studies thin data, 51 moderate richness of data, 5 grey literature high, 4 moderate and 3 low)	High Confidence	Graded as high confidence due to methodological strengths, relevance and adequacy.
Conceptualising and understanding emotional loneliness (n=24)	7, 8, 16, 19, 25, 30, 43, 55, 58, 61, 68, 74, 76, 82, 95, 106, 109, 112, 117, 118, 122, 123, 131, 132	Moderate concerns (3 studies had several limitations, 13 studies minor methodological limitations, 6 max. quality, 1 grey literature moderate and 1 high)	Minor concerns for relevance (all studies examined emotional loneliness)	Moderate concerns for coherence (data reasonably consistent within studies, low consistency across studies population/context)	Moderate concerns about adequacy (13 studies thin data, 9 moderate richness of data, 1 grey literature moderate, 1 high)	Moderate Confidence	Graded as moderate confidence due to moderate concerns with methodological limits, coherence and adequacy
Conceptualising and understanding existential loneliness (n=17)	18, 22, 24, 28, 49, 59, 60, 62, 64, 79, 83, 85, 87, 91, 93, 116, 134	Moderate concerns (3 studies several limitations, 8 minor methodological limitations, 5 max. quality, 1 grey literature moderate)	Minor concerns for relevance (all studies examined existential loneliness)	Moderate concerns for coherence (data reasonably consistent within studies, low consistency across studies on	Moderate concerns about adequacy (7 studies thin data, 9 moderate richness of data, 1	Moderate Confidence	Graded as moderate confidence due to moderate concerns with methodological limits, coherence and adequacy

				population and context)	grey literature moderate)		
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Conceptualising social loneliness

103 of the 144 included studies emphasised conceptualisations of social loneliness. Included studies explain social isolation as an objective condition related to the number of social connections and the structure of one's social environment. In all of these studies (see table 5 for study numbers), loneliness is explained as a subjective evaluation of feeling isolated, deprived of companionship, lacking a sense of belonging and without access to a satisfying social network. It has been argued that sharp distinctions between objective and subjective definitions of social isolation and loneliness may not advance understanding of each. ^[15, 127] Rather, conceptualisations based on meaning and emotions together with and possible measures of structural isolation could be more useful than simple counts of ties between individuals. ^[80, 127] While social isolation can compound social loneliness, being alone does not necessarily equate with loneliness, and it is possible to feel lonely in the presence of social connections. Voluntary withdrawal from social contacts for purposes of reflection and creative activity can be positive, ^[67, 70, 73, 107, 124] however, in the included studies social loneliness is overwhelmingly perceived as a negative and distressing experience. Overall, and in summary these studies show that social loneliness across the life course is fluid and temporal and represents an interplay between personal and intrapersonal factors, life events, loss, physical and mental limits, devaluing old age and wider socio-cultural, economic and political determinants.

Social loneliness in young people

Five studies examined young people's experience of social loneliness ^[56, 102, 120, 129, 141] three of which were focused on university students. ^[56, 102, 120]

The vocabulary of social loneliness articulated by young people described it as a painful feeling of being disconnected across many domains of life ^[129] involving feelings of helplessness, the need to escape from someone or something and submission to or resignation of negative feelings, often alongside feelings of shame and stigma. ^[56] One study examined youth worker perceptions of loneliness in young people. Youth workers reported high levels of social loneliness in young people as well as the difficulty of identifying the problem without exploring it with young people because they may not admit to loneliness. ^[141]

Social loneliness in young people is affected by changes and transitions, which can be compounded by difficult living situations, weak social networks, high expectations of social networks and cuts in services as well as by poverty and sexual, racial or cultural differences. ^[129, 141] While social media may present additional pressures, it can also offer young people the possibility of meaningful connections and positive relationships. ^[129]

Young people who move away from home to study may be at risk of social loneliness, which can be compounded by problematic institutional relationships and lack of support. ^[56, 120] One study of international students, viewed at particularly high risk, found that students from Asian countries characterised by collectivist cultures, studying in countries such as Australia where individualist cultures dominate, reported extreme social loneliness ^[120]. This was linked with feeling lost and in a strange place as well as facing settlement problems such as accessing housing and money ^[120]. The absence of intimate connections combined with a lack of cultural fit created 'cultural loneliness' in students who were missing their cultural and linguistic setting ^[120]. This notion of cultural loneliness is distinguished from other forms: cultural loneliness can persist even when people have good access to social networks.

A study of post-graduate students used the term 'academic loneliness' to describe a feeling of being apart, lacking a meaningful connection with a group, and experiencing unmet needs for emotional

support for personal difficulties. ^[56] This notion of academic loneliness contains elements of both social and emotional loneliness. ^[56, 120]

Studies reported a range of contextually and socially influenced coping strategies adopted by young people for managing loneliness and preserving and extending social connections. These include distraction, seeking help from professionals and institutions, support seeking, self-reliance and problem-solving behaviours. ^[56, 120] Although loneliness in young people is difficult to identify, youth workers can help to prevent a downward spiral by addressing loneliness risk at key moments which will differ amongst individuals but may be related to relationship concerns, mental health issues and a range of perceived stressors in life. ^[141] Efforts to improve mental health and wellbeing in student populations require strategic responses to loneliness from academic institutions. ^[56]

Social loneliness in paid and unpaid work

Social loneliness in employment has been studied in eight studies: of long haul truck drivers, ^[3] homeworkers, ^[32] school principals, ^[44, 47, 121] medical educators, ^[99] professional golfers, ^[21] and senior corporate managers ^[108]. Two studies examined informal carers' experiences of loneliness. ^[31, 101] Whilst many of these are single studies there are some employment features of paid and unpaid work that are drawn out as significant in understanding loneliness in working contexts. In particular lack of support, and employment related 'distancing' or isolation from others appears to compound social loneliness.

Employment related social loneliness can cause psychological distress, work disengagement, poor performance and burnout. ^[47, 99, 108, 121] It can compound work pressures and is linked with physical difficulties including sleep problems and substance misuse as well as detrimental effects on family dynamics. ^[3]

In these studies, conceptualisations of social loneliness relate to specific job roles, working conditions and organisational cultures. In jobs that require frequent mobility, social loneliness arises from the combination of work strain, separation from sources of support such as families, friends and communities, and weak professional and community support systems. ^[3, 21] For example, long haul truck drivers reported often missing out on important events and the day to day interactions that are vital for family bonding. ^[3]

Homeworkers experience social loneliness through a sense of professional isolation characterised by a lack of formal and informal interaction with colleagues, peers, and managers, limited opportunities for development, a weak sense of belonging, and a lack of being heard and opportunity to participate in decision-making. ^[32]

Social loneliness has been studied in relatively high-status positions as well as low status and low paid occupations. Within organisations, senior roles can give rise to social loneliness because of increased social distance and lack of support ^[108]. Many head teachers have experienced transitions from teaching roles where they were members of teams into roles where isolation may be perceived as a professional necessity. ^[44, 121] The notion of 'structural loneliness' has been used to describe the situation of school principals, who struggle between loneliness and belonging, balancing sharing approaches that are less lonely with non-sharing ones that avoid the risk of having to account for the failure of others. ^[44] Some organisational conditions, such as those characterised by the need to demonstrated power over others and remain distant from lower status positions can increase the risk of social loneliness. ^[108]

Studies of informal carers have identified social loneliness as a key theme. ^[31] Loneliness arises from the restrictions imposed by the caregiving role, including reduced personal space and emotional interaction, as well as relationship deprivations and losses and a sense of powerlessness, helplessness and sole responsibility. ^[101] Social encounters seemed to compound loneliness when

they were characterised by some form of distancing. Hence not feeling understood and being denied recognition for the caregiver role compound 'inner loneliness'. [101]

Studies reported a range of strategies for addressing workplace loneliness in different contexts, including provision of opportunities to socialise and maintain connections with people who provide social support. [3] The use of mobile technologies such as smartphones, has widened possibilities for homeworkers to socialise and get out of the home environment while retaining access to emails and remaining contactable by clients, although the use of technological devices does not necessarily address professional isolation in homeworkers. [32]

The extent to which senior managers feel lonely is also dependent on the coping strategies they use, which include mental and physical disconnection, adopting a healthy lifestyle, gaining support from one's network and affecting and influencing others. These findings provide an empirical foundation to manage social loneliness and improve the wellbeing of senior corporate managers. [108] In the two studies of school principals, sharing work tasks [44] and teamwork, networking, interaction with other teachers and good communication strategies [121] were also identified as important to alleviating feelings of social loneliness.

Programmes that seek to address workplace loneliness should be based on understanding sources of support and the way support is accessed as well as its practical effects and meaning. [99] Strategies to ameliorate social loneliness arising from organisation's roles include providing employees with the relevant theoretical frameworks to understand their structural position [44] and addressing organisational cultures that promote loneliness. [47, 108]

Measures to reduce loneliness in informal carers include practical support and opportunities for social connection, although social encounters that are not based on what is meaningful to those who are lonely may be insufficient and even unhelpful. [101]

Social loneliness in healthcare

The links between social loneliness and health conditions has been studied in relation to experiences of cancer, [1, 33, 37, 43] stroke, [2, 115] HIV/AIDS, [14, 34] aphasia, [48] mental illness, [50, 51, 70, 97, 133] brain injury, [84] and in General Practice [100]. These studies explore the way in which different experiences of illness and healthcare can lead to or compound social loneliness. For example, in stroke patients, feelings of isolation that arose from perceptions of the lack of availability of others, lack of support, a sense of being unable to contribute and not having an intimate relationship were linked with depressive symptoms and poor outcomes [115]. The design of healthcare environments has also been connected with social loneliness. For example, in one study, the design of a ward for stroke patients, while allowing privacy and supporting efficient clinical care, increased loneliness and created barriers to social connection. [2]

Attitudes and stigma emerged from several studies of people with HIV/AIDS and cancer. [1, 14, 33, 34] Feelings of alienation and stigmatisation based on perceived isolation from society were reported by men with HIV/AIDS, [14] and a study of women with HIV found that they were further isolated by their reluctance to seek out treatment and psychosocial support. [34] Stigma therefore led to a loss of social support, often compounded by factors such as poverty.

Negative perceptions of others' responses and negative social expectations were also identified in patients with cancer. [1] One study examined experiences of social loneliness in long term cancer survivors, identifying complex effects including persistent social isolation, which did not always diminish over time. [37] In cancer, experiences of social loneliness were compounded by a lack of access to people to whom those who have experienced cancer can relate. [33]

Five studies examined social loneliness in relation to mental illness. [50, 51, 70, 97, 133] Severe mental illness (SMI) has an effect of reducing or changing social networks, although many people with SMI desire to have greater social networks. [97] Loneliness is characterised as emotional and social exclusion, the feeling of 'looking upon the world through a frosted window'. [51] In mental health contexts, loneliness is affected by external environments, activities and therapies/treatment as well as people. [133] One study examined the relationship between financial strain and social isolation in people with severe mental illness, identifying barriers and stigmatising processes arising from having limited finances, difficulty inviting people to their home, and being unable to attend events in social spaces including at coffee shops or restaurants. [97]

One study explored experiences of social isolation and friendship with chronic stage traumatic brain injury (TBI) survivors who attended a social rehabilitation day programme. [84] Participants became less socially active and experienced a marked decrease in the number of friends following TBI. Social loneliness can arise due to physical, cognitive, behavioural and emotional responses following TBI, since these changes can affect existing relationships, leading to the loss of old friends, and create difficulties in making new friends. [84]

Study authors considered a range of strategies for addressing social loneliness in different healthcare contexts. For example, hospital design should consider the need to reduce loneliness by providing communal spaces and stimulating social environments while preserving privacy of patients and supporting efficiency. [2]

Responses of healthcare professionals, such as offering support and listening, can ameliorate social loneliness. [48] Appropriate follow up care, such as screening for long term social effects, would help people with long term conditions such as adult survivors of childhood cancers. [37] One study of GP perceptions noted that lonely people tend to consult GPs more often than non-lonely people, and that chronically lonely patients are more likely to evoke negative feelings and behaviour in their GPs. [100] GPs should try to recognise these emotions and make sure they do not have a negative influence during consultations. [100]

Provision of appropriate and accurate information and education for people accessing healthcare can help to address social loneliness in healthcare contexts [37]. Measures to alleviate social loneliness in people recovering from stroke include family education and increased awareness of practitioners of local support groups, services and other means of achieving support from within the community. [115]

Psychological therapies can address perceptions of social loneliness and provide support for patients in addressing stigma. [1, 14, 37] In long term cancer survivors, loneliness may be mediated by personal factors such as self-esteem but also by environmental factors including supportive care and societal attitudes. [37]

Mutual support and relating to other people with similar situations can help to address social isolation and loneliness for people experiencing a health crisis. For example, provision of opportunities, including virtual ones, to find others who people can relate to can facilitate expressive worth, sharing and psychosocial well-being in cancer survivors [33]. In the case of TBI, the authors suggest that rehabilitation programmes should focus on creating a safe, relational space for survivors and their families, as relating to other survivors is both a way of resisting cultural discourses about disability and offers a source of self-cohesion in the process of identity re-construction. [84]

In mental health, it is important to address wider social contexts in which people are living alongside the individual experiences those with mental health issues present. Such social conditions might include housing and employment issues and financial constraints. An improved economic situation is not a solution to all cases of social isolation and mental health distress, but it should be included among the various therapeutic resources offered to persons with mental health conditions. [97]

Provision of supported housing for people with psychiatric disabilities can help to manage or overcome loneliness.^[70]

Social loneliness and homelessness

Three studies examined social isolation and loneliness in people experiencing homelessness.^[10, 67, 119] Homelessness was linked with changes in the quantity and quality of relationships, including the loss of highly valued relationships with family, friends or intimate partners, the increasing centrality of relationships with other homeless people that were shallow and precarious.^[10] Hence social loneliness was linked with emotional loneliness in homelessness. One study found a wide variation in experiences being reported, including being socially related and content, being socially related and lonely and being isolated.^[67]

Stigma was also identified as a theme in relation to loneliness among homeless people. Rejection by the non-homeless served to constrain the way some participants positioned themselves in relation to others and their ability to connect socially.^[10] A study of homeless adolescents found high levels of loneliness, linked with dropping out of school and experiencing rejection by peers and particularly acute among those who had histories of traumatic childhood sexual abuse.^[119] Feelings of social connectedness, characterised by the belief that people in one's social network, including parents, friends and teachers, are caring for each other and doing things together, were positively related to wellbeing.

Social loneliness in prisoners

One study examined social loneliness in female prisoners, caused by separation from family from close attachment relationships, a lack of psychological support and long empty days in prison.^[20] Social loneliness is therefore linked with emotional loneliness in prison populations. One study found that a sense of grievance and loneliness may be heightened in people who commit serious offences such as murder.^[57]

Cultural and gender specificity of social loneliness

Seven studies examined aspects of loneliness that are more likely to affect women.^[7, 20 36, 40, 81, 98, 105, 130] Two studies examined issues specifically affecting men^[88, 39] and one study explored loneliness affecting transgender people^[114]. These studies identify detrimental impacts of social loneliness on mental health and wellbeing. They also point to the cultural and gender specificity of social loneliness and the importance of context in conceptualising loneliness.

In one study, women were found to experience loneliness as a result of family situations such as being at home with young children, adult children leaving home and bereavement, all of which can be compounded by poverty and lack of access to local amenities, job opportunities and personal social activities.^[7] A study of parents who were identified as socially isolated reported that social isolation was sometimes used as a self-devised strategy to limit social interactions that evoked feelings of fear.^[130] Hence parents' social isolation was complex and influenced by adverse life factors, often used as a protective strategy to make them feel more in control. The study on social loneliness in female prisoners emphasises that social loneliness is connected to negative impacts of being separated from family.^[20] Another study examined the experiences of women who had lived with domestic violence.^[105] The study notes the pervasiveness of loneliness, which is experienced on all ecological levels including within the self and in connection with the family of origin, the violent partner, the children and the extended family. Widowhood is also associated with social loneliness. One study emphasised the way in which widowhood led to social isolation because women were excluded from family and community events, increasingly marginalised and vulnerable to verbal and physical abuse.^[36]

In gender segregated traditional societies loneliness can be compounded by the lack of power that women experience and the presence of punitive family and social codes. [81] Two studies examined loneliness and social isolation in female migrants. [40, 98] A study of female Latina immigrants who had been exposed to trauma identified socioeconomic, environmental and psychosocial barriers to establishing social networks. [40] A study of female South Asian-Surinamese, Turkish and Moroccan migrants linked loneliness with gender identity in cultures that emphasise the need to preserve honour (through control of women's behaviours) and keep the family together. [98] Loneliness was described as a form of disempowerment arising from lack of autonomy, self-worth, restricted life choices, and lack of connectedness and affection. It was characterised as a sense of an unattainable meaningful life and was a contributory factor to suicidal behaviour or ideation [98].

One study explored the experiences of men's experiences of alienation following the decision to give up full time careers to stay at home and care for children. [88] The authors use the term, 'ideological isolation' to describe the effects of hegemonic masculinity that render it socially illegitimate for men to be involved in full time child-care, to be disengaged from the workforce, and to be supported by the earnings of women. Hence social loneliness is conceptualised as a consequence of transgressive gender practices that lead to alienation and ostracism.

Loneliness risk has been found to be higher in young men who have sex with men compared to their young male and female peers who may be straight or lesbian. One study found that loneliness, characterised as a desire for connection, influences the choices about their sexual behaviours of young men who have sex with men, sometimes leading to engagement in unsafe activities. [39] Programmes addressing young men who sleep with men tend to focus on HIV risk but they rarely address loneliness. There is a need for enhanced behavioural and psychological interventions targeting individuals and groups that actively address loneliness and social exclusion in this population group. [39]

Transgender people are identified as being at risk of social loneliness as a result of stigma, discrimination and social exclusion, compounded by factors such as poverty, HIV status, ethnicity, migration and class [114]. In one study, participants experienced negative encounters that increased their social anxiety and exacerbated social isolation. Participants responded by further isolating themselves, avoiding and restricting conversations, deflecting personal questions and, 'keeping people at arm's length'. [114]

These studies identify a range of coping strategies and measures to address culturally and gender specific forms of social loneliness. Successful strategies need to recognise loneliness as a cultural construct that is shaped by distinctive cultural contexts. [31] Women who experience loneliness in response to family roles and transitions sought to cope by engaging in local activities, hobbies, employment and volunteering in order to find a sense of purpose and have a social life. [7] Parents need to have their own needs for connection met as part of interventions to improve parent-child relationships. [130]

Supportive measures also include education and empowerment to address stigma and discrimination. For example, psychotherapy focused on reframing negative experiences can help women who have lived with violence to reframe negative experiences. [105] Programmes to address loneliness in disempowered women include education, autonomy-awareness programmes, support for women contesting imposed cultural norms and family counselling programmes that enhance mutual relationship building with families. [98]

Social loneliness and place-based approaches

The connections between loneliness and place have been explored in studies of specific urban and rural communities [9, 110, 143] and in areas at increased risk of natural disasters, where social isolation was reported as intensifying challenges in disaster preparedness and response. [38]

One study examined loneliness in residents of high-rise apartment communities, suggesting that social isolation arises from both physical and psychological distance between members of the community ^[110]. This study suggests that living alone does not necessarily lead to functional social isolation, however, social connectedness can reduce feelings of loneliness and isolation that can lead to serious psychological and other health issues.

One study examined a place-based education programme to reduce social isolation and social loneliness and enhance social support for low income parents. ^[9] Social loneliness connected to isolation was conceptualised in terms of the character of connections forged from participation across multiple settings including family, school, work, neighbourhood and faith community, whereas social support was conceived as a resource that is generated within specific geographical and relational contexts. ^[9]

A further study examined social loneliness in people from under-represented demographic groups in Scotland ^[143]. The study included women from BAME backgrounds, people living in economically deprived areas, in rural communities and paid and unpaid carers of people receiving palliative care. The study noted bi-directional relationships between loneliness, social isolation and mental health as is alluded to in some for the studies focusing on loneliness, healthcare and those living with psychiatric disorders. ^[97, 70] Loneliness and social isolation were characterised as forms of social exclusion, hence power, or the lack of it, relates to loneliness. In one UK based study of people who experienced loneliness across the life course and experts seeking to alleviate loneliness in different population groups, some physical and mental health impacts of loneliness were reported (e.g. stress, anxiety and depression). ^[144] In addition loneliness was connected to difficulties in developing meaning social engagement and was reported in terms of feeling trapped, angry and frustrated.

Place-based programs to increase social connectedness include friendships clubs and group activities ⁽¹¹⁰⁾. These can help to address social isolation by facilitating social support, addressing barriers and fostering social connections. ^[9, 40] However, structured opportunities for connection may need to extend beyond the duration of any single program, since stand-alone programs may ameliorate relational deficits, but are limited in their potential to address the institutional barriers of poverty that contribute to social loneliness. ^[9]

Social Loneliness and Older People

Forty-two of the 144 included studies focused on older populations (50+ years) and social loneliness. Seven studies examined older people's experience of social loneliness in healthcare. Nine studies considered social loneliness and issues of health and illness in community dwelling older people. Seven considered the impact of rural or urban places on social loneliness in older people. Migrant, cultural and/or gender specificity of social loneliness in older paper was examined in nine papers. Eight papers focused on experiences of social loneliness and the evaluation of services to alleviate social loneliness in older age.

Older people's experience of social loneliness in health and social care settings

The connections between social loneliness and older people receiving care has been examined in seven studies which focus variously on residents of nursing homes and other institutions, ^[65, 77, 78, 125, 136] care practitioners, ^[80] and in relation to moving from private homes to residential accommodation. ^[71]

Participants in nursing homes described social loneliness in terms of the perceived quality of their relationships and the extent to which such relationships were meaningful. ^[65, 71, 77, 78, 136] Older people did not always name loneliness as an issue but used other expressions to describe their days in

negative ways. ^[125] Cultural aspects of social loneliness were expressed by nursing home residents in which ethnic discrimination was noted as important. ^[77] Social loneliness was connected to a range of feelings by those living in nursing homes including boredom, being devalued, a sense of powerlessness, frustration, loss and pain/suffering and detachment, and social loneliness was spoken about with sadness. ^[65, 71, 77, 78, 125, 136] Isolation in older people was connected to feeling lonely and exacerbated by issues preventing carers providing adequate care (e.g. limited resources, time pressures and professional rules). ^[80] Provision of social activities to alleviate social loneliness in nursing homes could include a range of activities (e.g. self-awareness programmes, humour sessions, social engagements, faith-based activity) but were only associated with self-reported reductions in social loneliness if the activities were relevant to older people. ^[65, 77]

Social loneliness and issues of health, illness and wellbeing in community dwelling older people

The connections between ageing, social loneliness and health, illness and wellbeing are examined in studies of older people living in community settings. Studies examine social loneliness and elder mistreatment, ^[17, 105], the health and wellbeing of the old, very old and frail, ^[53, 89, 94] intergenerational approaches, the use of shelters and drop in centres, ^[67] and the role of community participation. ^[11, 23, 26]

Volunteers' accounts of elder financial fraud identified social loneliness as a key factor in making older people vulnerable to fraud either on the internet, by phone or in person. ^[17] In one study of older women facing domestic abuse in Israel, matchmaking practices were linked to loneliness in couple hood and the hidden nature of domestic abuse including prioritising children in family relationships exacerbated situations of social loneliness and the negative health and wellbeing consequences associated with it. ^[105] Therapy for older women who had experienced domestic abuse was explained as a way for these women to develop a way of coping with former experiences in later life. ^[105]

Three studies observed that social loneliness was connected to disruptions of meaningful engagement in later life which were associated with physical and psychological limits of old age, loss or relationships and identity, and feelings of exclusion and invisibility. ^[89, 94] Fatigue, tension, withdrawal and emptiness characterise social loneliness ^[89] and a struggle with physical frailty is a barrier to alleviating social loneliness in older people. ^[94] A life-long approach to positive health and wellbeing including an active lifestyle, maintenance of interpersonal relationships and an optimistic outlook were identified as important in preventing social isolation and social loneliness in old age ^[53, 89] and a more positive dimension of social loneliness in old age was associated with feelings of freedom in self-reflection and re-creation of meaning in life. ^[94]

Intergenerational approaches using reverse mentoring in which younger adults trained older people in the use of technology (IT) were reported by researchers as successful in alleviating self-reported social loneliness in older people in one study. ^[11] Intergenerational engagement and contact led to greater use of IT by older people, decreased social isolation and improved confidence and self-efficacy. Mentors also improved their leadership skills. In one study on older people using shelters and drop in centres, four overlapping types of social isolation were identified which connected to social loneliness: (i) socially related and content, (ii) satisfied loners, (iii) socially related but lonely and, (iv) socially isolated (and lonely). ^[67] Social isolation was connected to perceived lack of opportunities for social participation amongst older people as well as experiences of illness and disability and a sense of lost community in two studies. ^[23, 26] Addressing social isolation was linked to addressing social loneliness by considering the interplay between beliefs, fears, values and identity in old age. ^[23]

Comparing descriptions of social loneliness by those who were lonely with those who were not, revealed that both groups identified the negative aspects of the pain of loneliness but those who were not lonely felt those who were should cope with it themselves. [26]

The impact of rural or urban places on social loneliness in older people

The relationships between social loneliness, older people and place are explored in studies conducted in rural [5, 27, 54, 72] and urban settings [86, 107] and in a study of older people and perceptions of neighbourhood. [133]

Older people living in rural places identified that their experiences and understanding of social relationships and networks were tied to their sense of place. [5] Loneliness was experienced as a loss of community and reduced opportunity for shared activity in a place where people could feel they belonged in solidarity with others. [5, 27] Loss of an idealised sense of rural community represented by earlier times in their life contributed to older peoples' definition of social isolation and social loneliness. [5] In two other studies of rural living and older people, social loneliness was conceptualised as only partly defined in relation to social contact. [54, 72] Feelings of security in one's environment or place of living and one's ability to engage in activity to prevent loneliness were also central to understanding social loneliness. Socially isolated older people living in rural settings reported that loneliness was a consequence of the absence of people and inactivity but was also connected to personal perception and was connected to feeling vulnerable. [54, 72] Building and valuing community in a way that promoted independence and social support in rural communities was reported as a way to decrease social loneliness. [27] In one study, urban living was associated with a loss of community and a lack of solidarity. [86] An associated modern shift to technology and prioritisation of work was suggested to have devalued intergenerational and family connections and reduced face-to-face social contact important in alleviating social loneliness in older people. [86]

A study of older Chinese people living in an urban environment in Hong Kong explored the connections between environment, place, culture and social loneliness, reporting that insufficient value on the care and support of older people in contemporary society contributes to social loneliness through withdrawal of older people from social connections and activities. [107] Addressing these sources of social isolation is proposed as a way to alleviate feelings of vulnerability, helplessness and anger in older people, including enhancing programmes of support and care to include ways of encouraging positive attitudes to ageing.

Perceptions of living space as safe and secure served to limit a sense of social isolation. In determining the extent to which older people felt a sense of social loneliness, the need for safe spaces was interconnected with: the limiting effects of physical and mental illness; personal preference for social connection or solitude; subjective sense of aloneness (including fear of dying alone, loss of family and friend and lack of daily human contact); the quality of local amenities and services; and a sense of community (in shared public spaces, intergenerational living and housing characteristics). The findings of this study emphasise that place is central to feelings of social isolation. Living alone was associated with social isolation and social loneliness, however, for some participants a strong personal preference for solitude outweighed this. [133]

Migrant, cultural and/or gender specificity of social loneliness in older people

The migrant, cultural and/or gender specificity of social loneliness in older people is examined in relation to older women, [12, 36, 73] mixed cultural groups [13, 31] and groups identifying as Chinese living in Hong Kong [52] and the USA, [111] Asian (living in New Zealand) [66], and Nigerian (living in Nigeria). [63]

For older women taking prescription medication (benzodiazepine) for sleep or anxiety problems, loneliness was felt through social isolation. Loss of companions contributed to being alone and feeling

lonely which was associated with negative feelings of insecurity, depression and fear. ^[12, 36] In a study of Nepali women who had been widowed, loneliness was associated with reduced wellbeing through loss of a husband (as for all widows) but to the cultural consequences of widowhood in Nepal; exclusion from community and family, vulnerability to abuse and loss of economic security. ^[36] Immigration was identified as a life changing event that contributed to social loneliness in later life. ^[73] Older Sinhalese women living in Canada explained a connection between social and emotional loneliness through exclusions from family, loss of family (through death) and feelings of grief, sorrow, frustration, shame and desperation. ^[73] Yet these women also reported positive self-management of loneliness through inner belief and faith and determination to cope with the loneliness they experienced.

Stories told by African-American, Irish-American, and Chinese-American caregivers about caring for relatives with Alzheimer's disease, revealed that both biomedical and folk narratives of health inform understandings of extreme loneliness. Social loneliness was described by carers as tragic loss of a family member through deterioration of the brain and changing identities and the sense of family responsibility felt in caring for them. ^[31] A lack of meaningful relationships with 'co-ethnic' peers (people of the same ethnic background) was identified as a contributory factor in social loneliness of older carers and the people they cared for. ^[13]

In a study of Asian older women living in New Zealand, a lack of family contact in older age led to social isolation and feelings of hopelessness. ^[66] A study of Chinese migrants living in the USA identified that language and cultural barriers contributed to social loneliness which was connected to emotional loneliness in terms of feelings of loss, longing and grief and stress, anxiety and depression. ^[111] Nigerian older people in one study identified negative emotional aspects of social loneliness which was connected to physical limitations, negative perceptions of ageing, poor quality family relationships and a lack of opportunity for meaningful social engagement. ^[63] The consequences of such social isolation were associated with physical and financial mistreatment of older migrants reinforcing the idea that social loneliness in older age was a key public health issue. ^[31, 111] For older Chinese participants living in Hong Kong, social loneliness was alleviated through self-management, the legitimization of living alone and approaches to improving self-esteem and wellbeing. ^[52]

Services to alleviate social loneliness in older age

Studies focused on a diverse range of services to alleviate social loneliness in older age including friendship clubs, ^[29] music provision, ^[140] museum-based social prescribing, ^[142] defined community-based approaches, ^[6, 45, 90, 103, 138] and health messaging services. ^[35, 137]

In a UK charity programme to launch seventy friendship clubs, the provision of transport, venues and support in establishing networks of friends was identified as central to providing a quality experience in a friendship club. ^[29] A personal-asset based approach framed the organisation of the clubs in which its members learned to provide meaningful friendship and support for each other to address the impact of social isolation on negative feelings of social loneliness and adverse impact on health and wellbeing. Provision of a weekly singing group was identified in one study as a way of preventing social loneliness through the establishment of meaningful social relations through participant music champions who offer support and friendship to others ^[140]. Similarly, museum-based social prescribing was reported as a successful way to alleviate social loneliness in older people through meaningful social engagement, self-reflection and sharing experiences. ^[142]

Community-approaches to alleviating social loneliness were explored with community leaders working with older women and suggested that increasing independence, improving communication and developing mentoring, buddying and intergenerational befriending programmes could provide relevant support to older women ^[103]. An evaluation of community peer support groups identified the role of group activities as important to enhancing older peoples' social connections and sense of belonging as a way of alleviating social loneliness. ^[138] Three studies which emphasised the importance of

meaningful social connections and a focus on both social relationships and the development of positive attitudes to age and ageing in older participants themselves. [6, 45, 90] In one of these studies, older people expressed an ambivalence to programmes which primarily or solely emphasised a social purpose. [45] Older participants preferred services which were activity-based and allowed them to meet people with whom they had something in common, and where they were not labelled or stigmatised as lonely. [45, 90] Recognising the complexities of loneliness for diverse older people was considered important in community-based programming in particular in relation to changes in loneliness over the short, medium and long term and the capacity for older people to readjust to changing life circumstances including loss and death. [90] Studies emphasising the cultural specificity of social loneliness in older people identify the need to understand the personal histories and socio-cultural circumstances of older people in designing and implementing services to alleviate social loneliness. [12, 13, 31, 36, 52, 63, 66, 73, 111]

Studies of health messaging services for older people identified the need for excellent communication and appropriate content and style of material as central to the acceptability of messages about loneliness. [35, 137] Including the views of older people in the development of health messaging was reported as a way to ensure relevance and usability of materials. [35] Motivations to use a telephone service for older people revealed a 'buried loneliness'; people called for information but were really motivated by social loneliness connected to loss of family, friends and community, being housebound [137]. In this study, 'everyday companionship' was identified as a way to alleviate social loneliness in older people.

Conceptualising emotional loneliness

Twenty-four of the 144 included studies emphasised conceptualisations of emotional loneliness. Emotional loneliness is conceptualised in the included studies in this review as a dynamic of negative and positive emotions which are constructed differently according to diverse experiences across the life course. Emotional loneliness can be both acute, temporary and subject to negotiation and change, and permanent, long lasting and damaging to mental and physical health.

A 'loss model' or 'relationship deficit' approach was commonly used to explain emotional loneliness. Negative emotions identified in conceptualisations of emotional loneliness included sadness fear, anxiety and worry. Such emotions were connected to feelings of disconnection, withdrawal, alienation and exclusion from people and places and also a sense of abandonment. Positive emotions connected to emotional loneliness were conceptualised in terms of optimistic perceptions of aloneness and solitude associated with learning to cope with loneliness, and adjusting to imposed loneliness.

Twenty-three studies in this review reported on emotional loneliness in community contexts and one [112] in a nursing home. The included studies focused on specific stages of the life course (older age and youth), life experiences (widowhood and physical and/or mental health conditions) and family context and we report on these topics. In addition, we report on studies showing the interconnections between emotional loneliness, social relationships and place.

Emotional loneliness across the life course

Of the twenty-four studies on emotional loneliness only one focused on emotional loneliness in young people and this highlighted those living with a parent diagnosed with cancer. [43] Young people in the study reported a sense of physical and psychological loneliness despite being surrounded by healthcare professionals, family and friends. Emotional loneliness was characterised by a sense of

exclusion by the failure of professionals to explain the situation to them, being left out of decisions and conversations connected to diagnoses and treatment of their parents and they felt a sense of longing for their parents. Feelings of uncertainty about the future, fear of losing a parent and a sense that they were not equipped to cope generated a sense of distance or disconnect from others. Alleviating this kind of emotional loneliness was associated with support and comfort offered by family members and being given accurate information by healthcare professionals which combined to provide a sense of relief from emotional loneliness for young people.

Twenty-three included studies focused on conceptualising emotional loneliness in old age (50+ years). In three studies, emotional loneliness was explained by older age participants as an inevitable part of the experience of ageing such as physical and cognitive decline, [8, 16, 58, 68, 109, 95] the diagnoses of a chronic condition such as cancer [112] or the onset of later life depression. [109] Negative emotions were an integral and overarching characteristic in conceptualising emotional loneliness with a wide and diverse range of adverse and undesirable emotions being felt by older people. Feelings of loss, [8, 16, 19, 25, 55, 58, 109, 122, 131], disconnection, withdrawal, detachment or alienation from people and places, [19, 109, 117, 131] a feeling of abandonment, [25, 68] exclusion [58] and a sense of losing or conflicting with ones' established identity [19, 55, 74, 76] were descriptions of emotional loneliness in old age. Emotional loneliness was described by older age people in the included studies as a type of inner pain or suffering, a feeling to be kept hidden and silent because of fears of being stigmatised as lonely and old, becoming a burden on family and friends and feeling responsible for controlling emotional aspects of loneliness. [55, 58, 109, 112]

Feelings of sadness, fear, worry and anxiety were articulated in narratives of emotional loneliness and old age. [8, 16, 30, 95] Furthermore, the temporal and spatial aspects of emotional loneliness were drawn out in explanations that older age and associated life events led to a change in the sense of the timing and pattern of life, alterations in the type, frequency and numbers of interactions with other people, and a change in the places, spaces and activities that older people engaged with, [8, 16, 19, 30, 58, 68, 95] as well as being described as permanent and damaging, [16] acute [19] and associated with time-related feelings of impatience and worry for the future. [30]

Positive feelings associated with emotional loneliness in older age were reported in studies in this review and associated with the perceived benefits of solitude or aloneness. 25, 95, 68 Solitude was connected to feelings of freedom and a sense of comfort in old age in one study and defined as 'at homeness'. 25 Being able to cope with emotional loneliness in old age was associated with a sense of joy and pride in oneself 95 and emotional self-management. 68 Included studies in this review examined processes of negotiating and adapting to loneliness in old age. Alleviating emotional loneliness was connected to establishing new routines to account for the loss of loved ones or social networks, 19, 117, including developing opportunities for meaningful social contact, 131 engaging in therapy for those living with long-term mental health conditions, 58 and taking part in meaningful activities including reading, gardening and social meals. 68, 112

Emotional loneliness through the loss of a spouse (widowhood)

Widowhood was discussed in one study in terms of social loneliness as detailed previously. [36] However, losing a spouse (becoming a widow or widower) in older age for both men and women was identified in four studies as a specific life event which was associated with emotional loneliness and conceptualised in terms of a cognitive deficit or loss model. [8, 19, 16, 118] Grief and the demise of intimate relationships was a trigger for emotional loneliness in these studies. Participants in another study reported that emotional loneliness connected to a long-lasting feeling of grief was more permanent and harmful. [16]

The role of supportive and intimate bonds with siblings was reported in one study as central to managing emotional loneliness in widowhood. [118] In another study, the change in patterns of time and loss of social relations experienced through the loss of a spouse led to acute emotional loneliness

but this could be negotiated to established new everyday routines to account for the feelings of grief connected to the loss of a loved one. ^[19]

Emotional loneliness and physical and mental health conditions

Six included studies conceptualised emotional loneliness in relation to personal experiences of living with a physical or mental health condition. ^[58, 61, 82, 95, 109, 112, 117] These studies included diverse populations including women living with chronic conditions. ^[95, 117] and older people living with cancer ^[112], long term mental health conditions, ^[58] learning disability, ^[61] and later life depression. ^[109] These experiences contributed to emotional loneliness through changing social relationships, a sense of detachment from people and a longing for loved ones alongside feelings of sadness, disconnection, fear, anger and worry loss of self and detachment from life as well as feelings of loss, exclusion and absence of meaningful relationships. Approaches to alleviating loneliness for those living with physical and mental health conditions included nostalgic activities allowing remembering and reminiscing about happy times, keeping busy, and engaging in activities which included meeting people could lead to feelings of pride in self-management. ^[58, 95, 112, 117] Participating in therapy was also considered to help strengthen a sense of connection to the world for those living with mental health conditions. ^[58]

Emotional loneliness in family contexts

Family contexts were emphasised in conceptualising emotional loneliness in six included studies. ^[7, 74, 106, 118, 123, 132] Emotional loneliness experienced by women was reported in terms of changing family circumstances over time including children leaving home and bereavement ^[7] with consequent feelings of loss and detachment which were more marked in situations of low income and which had a detrimental effect on health and wellbeing and mental resilience. The role of a family life course perspective in understanding emotional loneliness was addressed in terms of sibling relationships and widowhood in one study ^[118]. In a study of parents who had experienced the death of a child, grief was central to the conceptualising of 'intimate loneliness'. ^[74] The internalisation of emotions led to an inability to communicate and a strong sense of losing oneself. In a study of the children of holocaust survivors, the trauma experienced by parents contributed to emotional loneliness in childhood through intergenerational exchange of the trauma experience. ^[106] Feelings of not being understood and needing to understand their parents' experiences characterised emotional loneliness in this study which was influenced by physical and emotional detachment of the parent, echoes / memories of trauma expressed by parents, inadequate care of children and negative comparisons to other families.

Being or becoming single (not in a partnership) was identified by participants as a determinant of emotional loneliness in a study of older couples who also associated enhanced quality of social relationships with being married. ^[123] Marriage can be protective against emotional loneliness although not if the relationship is problematic. ¹³² Unfulfilling and unhappy marriage was explained in terms of feelings of disappointment, abandonment, powerlessness, guilt and a sense of being devalued. Alleviating emotional loneliness in family situations was connected to a personal asset-based approach for developing a sense of social purpose, and engagement in community and neighbourhood. ^[7] Adjusting to loss in family situations involved personal responses and strategies for creating and making sense of a new identity. ^[74] Strong sibling bonds were reported as central to support networks and positive feelings of intimacy required to cope with widowhood. In situations where sibling bonds were weak or inadequate, emotional loneliness associated with feelings of grief, discomfort and a longing for restoration of relationship deficits was reported. ^[118]

Emotional loneliness, social relationships and place

A common theme in conceptualisation of emotional loneliness in included studies was the connection between emotional loneliness and social isolation; an incongruence between desired and actual

social relations. Emotional loneliness was associated with loss or lack of good quality social relationships in all the included studies in this theme. The sense of loss, disconnection, withdrawal, detachment or alienation from people and places and feelings of abandonment and exclusion was also commonly discussed and particularly in relation to older people (see section on emotional loneliness across the life course). Additionally, one study identified the antecedents of emotional loneliness in terms of the interplay between the quality of social relationships, experience of traumatic life experiences and negative self-perceptions.^[76] Rural isolation was connected to a sense of physical detachment from people and a lack of social support.^[95, 117] Alleviating emotional loneliness associated with insecurity or a lack of attachment to place, either rural or urban, was reported in one study as a trigger for emotional loneliness.¹²² Creating place-based opportunities for the development of a sense of neighbourhood was suggested in one study as a potential solution to emotional loneliness.^[131]

Conceptualising existential loneliness

Seventeen of the 144 included studies emphasised conceptualisations of existential loneliness. Existential loneliness offers a different perspective on loneliness from the emotional or social in that it is conceptualised as a feeling of fundamental separateness from others and the wider world and not simply as the absence of meaningful relationships. Participants in included studies describe it as a feeling that occurs when important others are absent through rejection or when people feel left behind by life events such as death or divorce and/or experiences of physical or mental decline or limitation and a sense of one's mortality. This conceptualisation of existential loneliness is connected in all studies examining the concept to feelings of separateness from other human beings, feelings of loss and longing and/or a sense of being an outsider against a need for connectedness, belonging and companionship. Existential loneliness may also be felt while with others; a sense of loneliness in a group. In such situations, participants in studies report that loneliness is experienced through being misunderstood and/or psychologically and emotionally detached. Existential loneliness perceived as being without others commonly leads to a sense of stigma.

Existential loneliness is not always conceived of as negative experience. Evidence included in this review understood existential loneliness in one study as restful and creative if voluntarily chosen.^[18] Such self-directed and potentially positive experiences of loneliness are conceptualised as a powerful force for calm and peace; a type of recharging experience adopted when people feel a need to break from human connection for a while. While old age, frailty and impending death are most often considered in the context of negative feelings of loneliness there is evidence in two studies that such life experiences contribute to an understanding of loneliness as a balance between solitude and meaningful human connections that involve both social and emotional experiences, and the building of new and trusting relationships.^[87, 116]

Existential loneliness and physical and mental illness

Negative feelings of existential loneliness have been connected to healthcare contexts via the concept of the 'lonely patient' who, while in close proximity to other patients or health care professionals, may feel disconnected because of a sense of vulnerability or lack of care^[18,24] or issues of communication.^[62] In a study of participants with aphasia, the inability to communicate effectively was linked to a feeling of being detached from others and alienated from everyday life.^[62] In a study of cancer patients facing the consequences of infertility, communication challenges were reported by patients as a contributing factor in their experiences of existential loneliness.^[24] Patients reported that healthcare professionals did not possess the requisite knowledge of infertility and tended to over focus on surviving cancer rather than dealing with the issue that patients perceived to be more sensitive; infertility. In addition, the emphasis by healthcare professionals on positivity was

reported by patients as a mechanism for avoiding the harsher realities of cancer and infertility. Not communicating about their situation by wishing to spare close family or friends from devastating news through emotional control of their feelings was also cited as a source of existential loneliness. [24]

A study of breast cancer survivors' existential loneliness was defined as 'survivor loneliness' and involved a transcendent experience including an emerging consciousness about living with and beyond cancer, disruption of time, inauthentic sense of self (being a hero / being expected to cope), fragile relationships and withholding the truth. [79] In a study of palliative care in cancer patients (age range 21-91 years), an impending sense of death was reported as the primary source of existential loneliness. [85] Thoughts about death elicited a feeling that the physical body was becoming separate from the world which created a sense of unfamiliarity, powerlessness and vulnerability compounded by feelings of, being avoided and left alone by others and treated with fear and a lack of understanding. [85]

A sense of physical separation was identified in studies examining existential loneliness. In a study of participants with severe mental illness who had experienced admission to a psychiatric unit, existential loneliness was explained as feeling excluded from 'normal' life, forgotten by friends and abandoned. [59] Two studies reported on individual, single case studies of patients receiving psychotherapy for anxiety and depression. [22, 134] These studies argue that such mental health conditions are the result of a disturbed self-image associated with a failure to develop positive connections to others. Existential loneliness is described as a separation from other people but centrally reflects a disruption of perceptions of time and an inability to see the possibilities of the present moment. Such experiences have been defined as 'desperate loneliness' by authors of the study [22] and associated with strong feelings of hopelessness and inability to cope. Existential loneliness is again described in terms of feelings of loss, disconnection from the world, a fear of aloneness and a sense of being unprotected. A study of female immigrants who were on long-term sick leave from work showed that existential loneliness was the triple feeling of separation resulting from being locked inside one's home, detached from one's country of origin and rejected in the workplace. [60] Cultural and linguistic differences at work served to create this sense of detachment and exclusion for these women for whom severe feelings of existential loneliness were also connected to suicide ideation. In another study of internet suicide pacts (focus on Japan), feelings of existential loneliness were also connected to suicide ideation and a cultural sense of comfort was identified in the idea of dying with others rather than alone. [64]

One other study that examined existential loneliness in those with borderline personality disorder (BPD) defined the experience of loneliness as a chronic, life long, inherent feeling of emptiness [83]. People experiencing loneliness in this way are unable to feel comfortable with or connected to people and experience a traumatic life. Feelings of being stigmatised are reported by people with BPD, as is a sense of feeling like an outsider in the world. In a study of combat-related trauma in veterans who had experienced captivity, existential loneliness was characterised by feelings of extreme alienation from the world. [91] For participants in this study the experience of combat and captivity lay outside the range of normal human experience or language (communication) making it impossible for them to develop a sense of shared identity with people. [91]

In a study with healthcare professionals, a focus on the perceptions about loneliness of the frail older people in their care, concluded that staff recognised existential loneliness in those they cared for in terms of feelings of insecurity, fear, and difficulties in addressing physical and cognitive challenge. [93] Participants emphasised the need for them to understand existential loneliness and employ empathy, compassion and an open-minded approach in their professional practice that also recognised the complexity and specificity of peoples' life histories, including their culture background and its connection to feelings of existential loneliness.

Existential loneliness and older people living in community dwellings

Work emphasising the importance of conceptualising existential loneliness was reported in three studies about older population groups and highlighted the importance of both loss and resultant disconnection. [28, 49, 87]

A study of older people receiving home care, conceptualised existential loneliness in relation to a profound sense of suffering through a disconnection from life. [28] A sense of loss framed this experience of loneliness in three overlapping ways: (i) loss of connection to a life partner; (ii) loss of meaningful activity due to social isolation, and (ii) loss of health through physical frailty. The experience of frailty in old age was central to conceptualising existential loneliness in two studies. [49, 87] The combination of biological and cognitive decline was significant in feelings of existential loneliness through the limitations of body, the restrictions of space and place and the disconnection from other people through the associated lack of capacity to engage with others. [49] A sense of disconnection is also reported by older frail people in terms of a lack of intimacy and acknowledgement that a life lacking in meaningful exchange creates a subjective experience of existential loneliness. [87] The loss of a partner was also reported by participants as significant in eliciting feelings of existential loneliness in this population group. [49, 87] Decline, loss and frailty in older age, then, present people with an awareness of their own mortality; a disconnection from life which is characterised by both social and emotional factors. For older people living with chronic conditions, existential loneliness was described as a sense of emptiness and detachment from the world and connection to negative emotions such as sadness, anxiety, anger and guilt. [116]

Evidence of addressing loneliness and inequalities through conceptual studies on loneliness

The studies in this review variously reported on or specifically emphasised the demographic characteristics of participants including marital status, ethnicity, gender, age, and cognitive or physical illness or disability and these studies identify some aspects of the specificity of loneliness that is associated with inequality. However, no studies in this review presented a detailed analysis of the relationship between conceptualising and understanding loneliness, alleviating loneliness and inequality.

Completeness of the included evidence

The inclusive and open review question, precise search terms and focus on conceptual and theoretical approaches to loneliness returned a high number of relevant studies for inclusion. Some studies were not available within the short timeframe for this review and we excluded studies not in English meaning that some relevant studies may have been excluded. However, the systematic search strategy ensures that this overview represents a comprehensive summary of all existing eligible studies published prior to the search dates.

Summary statement on quality of the included evidence

Overall the quality of included studies was mixed but more studies were rated as higher quality (6+/8) than of lower quality. There is an extensive body of qualitative literature which conceptualises loneliness and does so by describing experiences at different stages or points in the life course and for diverse population groups in different settings and contexts. We can have high confidence that the evidence in this review contributes to conceptualising social loneliness and moderate confidence that the evidence contributes to conceptualising emotional loneliness and existential loneliness.

The rating of moderate confidence is due to minor concerns with relevance, and moderate concerns with methodological limitations, coherence and adequacy. Most published studies obtained appropriate ethics approval, although this was not always reported extensively. Methodological

weaknesses of these qualitative studies included a lack of exact details of the researcher's role, potential bias and influence on sample recruitment, setting and responses of participants. Grey literature was of mixed quality with high quality reports including details of methods, theoretical analysis and recognition of limitations and low quality (credibility) reports providing little detail of methods and commonly taking participant accounts at face value without theoretical analysis.

Strengths and limitations of the review process

The rigorous and systematic search strategy and comprehensive nature of this review is a strength. The focus on concepts, models, theories and frameworks of loneliness means that it is possible that some relevant evidence is not included. The pre-publication of our protocol on PROSPERO ensures methodological transparency and mitigates against potential post-hoc decision making which can introduce bias to the process. Dual screening of searches and data extraction and independent quality assessment of included reviews ensured a rigorous process.

There is a potential risk of publication lag, wherein possible important new evidence that has not yet been included in published articles and reports and is not identified and included.

The use of the CERQual criteria introduces an element of subjective judgement. A consistent approach to judgements across the different interventions has been applied but it should be recognised that these judgements are open to interpretation.

Implications for research, policy and practice

1. The conceptualisation of social loneliness, emotional loneliness and existential loneliness reported in this review reflects established theoretical frameworks for understanding loneliness and can be recommended for decision making in policy and practice
2. The evaluation of the findings in this review of moderate confidence in the evidence for emotional and existential types of loneliness largely relates to methodological issues in the conduct of the research. There is, therefore, considerable potential to generate a more robust evidence base for policy and practice, especially prevention and intervention development and evaluation.
3. There is an extensive body of qualitative research conceptualising predominantly social loneliness. This understates the significance of emotional and existential loneliness. Therefore, there is scope in research, policy and practice to explore in more detail the different types of loneliness and their interrelationships to understand who feels lonely, when where and in what contexts. This suggests a need to evaluate the way loneliness is conceptualised in our commonly used measurement tools. This will offer an evidence-based foundation for developing policy and practice and developing more tailored interventions.
4. Most studies focus on older people and we would recommend studies which focus on a wider range of age groups in different social contexts.
5. There is a dearth of studies focusing on loneliness in young people and we would recommend studies which focus on this population group.
6. A more sophisticated approach to understanding loneliness in the life course should recognise issues of transition and change, and examine how experiences are influenced by specific socio-cultural and personal influences which have an impact on subsequent life trajectory.
7. A more sophisticated approach to understanding conceptualisations of loneliness and key theoretically informed issues including identity (e.g. gender, ethnicity, disability, socio-economic status), trauma or survivorship and stigma.
8. The extensive qualitative literature conceptualising loneliness is mainly reported separately from quantitative studies. We would recommend high quality mixed methods study designs that employ rigorous and systematic quantitative methods, longitudinal process evaluations and cost effectiveness evaluations.

9. Research, policy and practice approaches to loneliness can be enhanced through coproduction methods involving mutually beneficial working practices in service design, implementation and evaluation.

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Appendix 1 Data extraction form including CASP quality check (published literature)

Data Extraction Form (conceptual review of loneliness, CSC): Reviewer Initials:

Author, Year, Title	
Location	
Study objectives	
Study design	
Brief description of the study	
Participants included Describe details of the participants including a focus on protected characteristics (age, gender, race, sexuality, etc.), socio-economic status, sample type (e.g. community, individuals, groups), and location of the study.	
Details of analysis and evaluation Evaluation and analysis approaches to conceptualising loneliness including relevant measures and/or analysis of mechanisms and processes associated with loneliness. (Include type of analysis i.e. quantitative/qualitative/mixed method and/or process of analysis e.g. thematic analysis/statistical analysis, any subgroup analysis; include details of loneliness measures if relevant)	
Describe how loneliness is defined/conceptualised in the study (Include definitions of loneliness and theories,	

models, concepts or frameworks used)			
For Qualitative Themes For qualitative data what categories/themes were identified that conceptualise loneliness, what results are reported, and what evidence provided to support conceptualisation of loneliness			
Study conclusions (relevant to this conceptual review)			
Limitations identified (List any limitations described by the authors)			
Conflicts of interest and sources of funding			
Ethical procedures reported			
Quality of individual papers (based on CASP Checklist)			
	Y	N	CAN'T TELL
Was there a clear statement of the aims of the research?			
Is a qualitative methodology appropriate?			
If answer to both questions above is Y, then proceed with the questions below			
Was the research design appropriate to address the aims of the research?			
Was the recruitment strategy appropriate to the aims of the research?			
Was the data collected in a way that addressed the research issue?			
Has the relationship between researcher and			

participants been adequately considered?			
Have ethical issues been taken into consideration?			
Was the data analysis sufficiently rigorous?			
Is there a clear statement of findings?			



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