

Loneliness in aged and older Adults in Nigeria

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ABSTRACT:

Background: Loneliness has been associated with many physiological changes which often serve as precursor to ill health. Feelings of isolation, or loneliness increases fear in people leading to vigilance and heighten feelings being unsafe. This distressing feeling can result in many physical and mental disorders with consequent reduction in the quality of life.

Aim and Objectives: This study investigated the phenomenon of loneliness among middle aged and elderly, mentally ill patients and determined the characteristics of people who are more prone loneliness. **Methods:** In this cross-sectional study, psychogeriatric patients who consented were assessed for loneliness using a standard questionnaire, the 20-item University of California Loneliness Assessment scale (UCLA scale). **Results:** Majority of the patients who attend psychogeriatric clinic are females, 76% of the patients are married and a large proportion of them (28%) are retired civilian servants and retired security personnel. Dementia is the commonest mental disorder in this sub specialty clinic. More males were rated as lonely than females. Discussion: Loneliness is present in all age groups and in both gender. It has long been associated with increased risk of diseases. **Conclusion:** Loneliness is generally common among elderly people, most especially those without spouses, clinicians are therefore encouraged to assess and mitigate it.

Keywords: loneliness, middle age, older adults, psycho-geriatrics, Nigeria.

INTRODUCTION:

Loneliness is feeling alone or disconnected from others. It is feeling like you do not have meaningful or close relationships or a sense of belonging.

It can be defined as a distressing feeling that accompanies the perception that one's social needs are not being met by the quantity or especially the quality of one's social relationships^{1,2}.

According to Weeks³, loneliness is a common experience; as many as 40% of adults over 65 years of age report being lonely at least sometimes. It is typically measured by asking individuals to respond to items such as those on the frequently used UCLA Loneliness Scale⁴. A growing body of longitudinal research indicates that loneliness predicts increased morbidity and mortality⁵.

It reflects the difference between a person's actual and desired level of connection. Another closely related concept, social isolation is when a person does not have relationships or contact with others.

Impact of loneliness on Mental Health:

A recent review of the literature showed its negative impact on cognition⁶. Loneliness has been associated with personality disorders and psychoses^{7,8}, suicide⁹, impaired cognitive performance and cognitive decline¹⁰. It has also been linked to increased risk of Alzheimer's Disease, diminished executive control and increase in depressive symptoms¹¹, and dementia. Loneliness has also been associated with anxiety, suicidality and deliberate self-harm.

Previous studies reported loneliness as a common experience; as many as 40% of adults over 65 years of age report being lonely at least sometimes³.

The concepts of social isolation and loneliness have been defined in different ways, which has led to variability in how these concepts are measured. The use of standardized and validated measurement tools help build a more robust evidence base in which results are comparable to other studies.

Many instruments are available for measuring social isolation and loneliness thus:-

Tools for measuring loneliness and social isolation:

The Berkman–Syme Social Network Index focuses on the general adult population and measures social integration versus isolation eg, frequency of contact with other people, participation in religious activities, and other activities (Berkman and Syme, 1979)¹².

Steptoe Social Isolation Index. Steptoe and colleagues (2013), created an index of social isolation which is a five-point scale¹³.

The Duke Social Support Index is a 35-item measure of various dimensions of social support, including social network (e.g., proximity of family), social interaction (e.g., frequency of interactions), subjective support (e.g., perceptions of relationships), and instrumental support (e.g., availability of help). The interview required for this measure is long, as a result, two abbreviated versions of the tool have been developed: an 11-item and a 23-item scale (Koenig et al., 1993)¹⁴.

de Jong Gierveld Loneliness Scale. The de Jong Gierveld Loneliness Scale is an 11-item questionnaire, a shortened 6-item scale comprising two of the 3-item subscales within the original 11-item questionnaire has been used (de Jong Gierveld and Van Tilburg, 2006)¹⁵.

The UCLA Loneliness Scale is a 20-item, self-administered questionnaire that has become the gold standard for measurement of subjective loneliness (Russell, 1996)¹⁶. For this reason, we decided to select it among all the other instruments and use it in this study. In the UCLA Loneliness scale, the possible responses range from 'not at all' (1) to 'often' (4). The total score thus ranges from 20 to 80, with a higher score reflecting higher loneliness (Russell, Peplau, & Ferguson, 1978)¹⁷. A total score <28 = no/low loneliness, total score of 28-43 = moderate loneliness and a total score >43 = a high degree of loneliness. For the purpose of this study, only those with a high degree of loneliness (UCLA mean scores above 43) were categorized as lonely, while those with low to moderate loneliness (score of 20 -43) were classified as not lonely.

MATERIALS AND METHOD:

This was a cross-sectional hospital-based study on participants who were out-patients in the psychogeriatric clinic. The psychogeriatric clinic of Jos University Teaching Hospital takes place every Friday at the Medical Out Patient Department (MOPD). Jos University Teaching Hospital is located in Jos, Plateau State, North central Nigeria. This clinic is a sub-specialty clinic run by department of Psychiatry and comprises of elderly patients who have mental illnesses and who sometimes also have comorbid physical illnesses.

The age of adulthood is subdivided into young adults which comprises of people aged between 18 to 39 years, middle aged adults, i.e those aged between 40 to 59 years while older adults are those above 60 years. The psycho-geriatric clinic comprises of the middle age adults and the older adults, hence the focus of this study.

After obtaining ethical clearance for this study from the relevant authority, the patients who consented to participate in the study were each given a socio-demography and clinical symptoms questionnaire designed by the authors for this study as well as the 20-item University of California Loneliness scale (UCLA Loneliness Scale) to fill during their consultation in the clinic. Data was collected on four consecutive Fridays in the month of March, 2025.

The questionnaires were designed to be self-administered by the respondents. However, in some instances where the patient could not read and write in English because of lack of education, the researchers or the informant (i.e the relative who accompanied the patient to the hospital) read out the questions to the patient in a language the patient understands, the patient's answers are then written against each question and submitted to the research team.

RESULTS:

A total of 42 patients participated in the study comprising of twenty-eight females (66.6%) and fourteen males or 33.3%. The mean age of 54.6 years indicate that most of the patients were middle age and older adults. Most (>60%) of them had low level of education of primary education or no formal education at all.

Majority are Christians and over 76% were married. Other socio-demographic characteristics are as shown in Table 1.

The most common mental illness was dementia, present in 38% of the respondents, 26 % had depression, and 20% had schizophrenia. See figure 1.

Concerning co-morbid conditions, Sixteen percent (16%) of the respondents had no comorbid physical illness:

Among the patients who had mental illness coexisting with a physical disorder, Cardiovascular diseases such as hypertension, ischaemic heart diseases, stroke and others were the commonest co-morbid disorders. This was followed by disorders of the gastrointestinal tract (gastritis, peptic ulcers, non -ulcer dyspepsia) then endocrine disorders e.g diabetes mellitus in that order as shown in figure 2.

Many of them reported loneliness and social isolation as indicated by their scores on the loneliness scale. The

males experienced more loneliness than female, the younger age group were less lonely while those who had no spouse (single, divorced or separated) had the highest rate of loneliness.

The average prevalence of loneliness in the entire sample was calculated and found to be about 17.85% with males reporting more loneliness (21.4%) than females (14.3%) as shown in table 2.

Table 1. Socio demographic characteristics.

Variables	Frequency	Percent %
Gender		
Male	14	33.3
Female	28	66.7
Age (mean $\pm$ S.D) (years)	54 $\pm$ 6	
Level of education		
None	8	19.1
Primary	18	42.9
Secondary	10	23.8
Tertiary	6	14.3
Religion		
Christianity	26	61.9
Islam	16	38.1
Marital status		
Married	32	76.2
Single	2	4.8
Widow(er)	5	11.9
Divorced	3	7.1
Occupation		
Unemployed	6	14.3
Retired	12	28.6
Farming	11	26.2
Civil service	9	21.4
Business	4	9.5

Figure 1. Mental disorders.

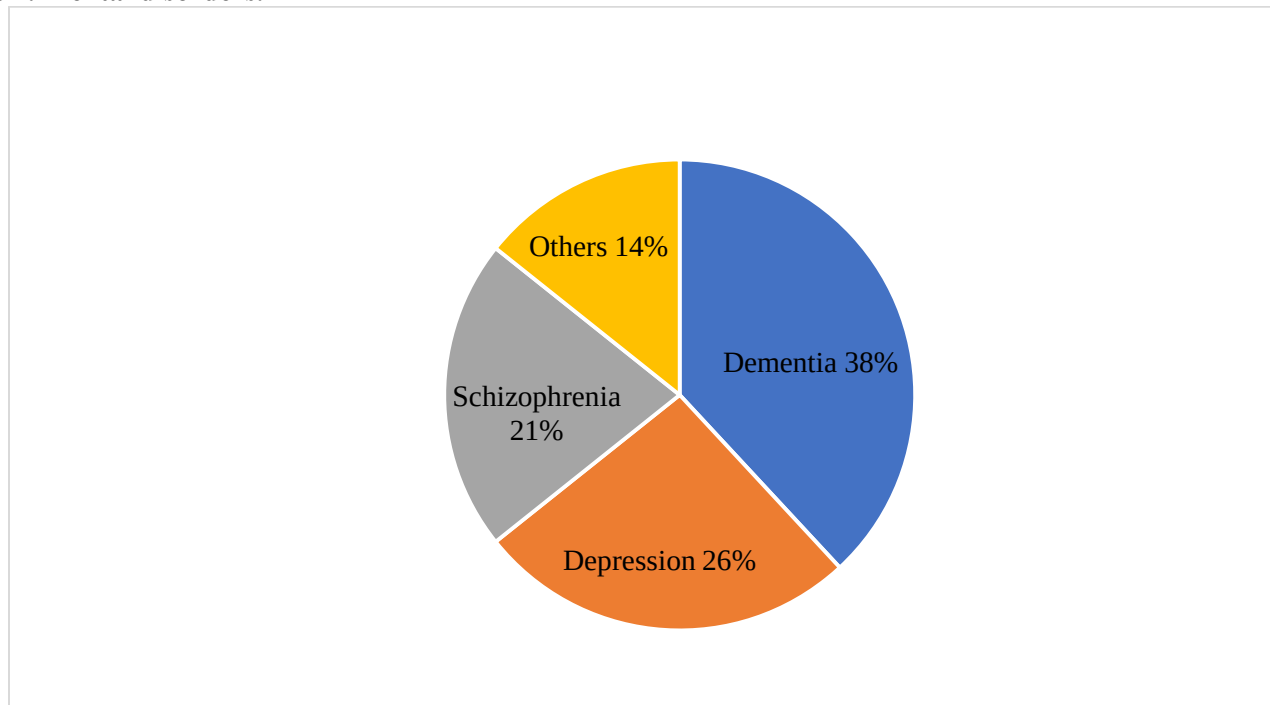


Figure 2. Co-morbid Physical illnesses.

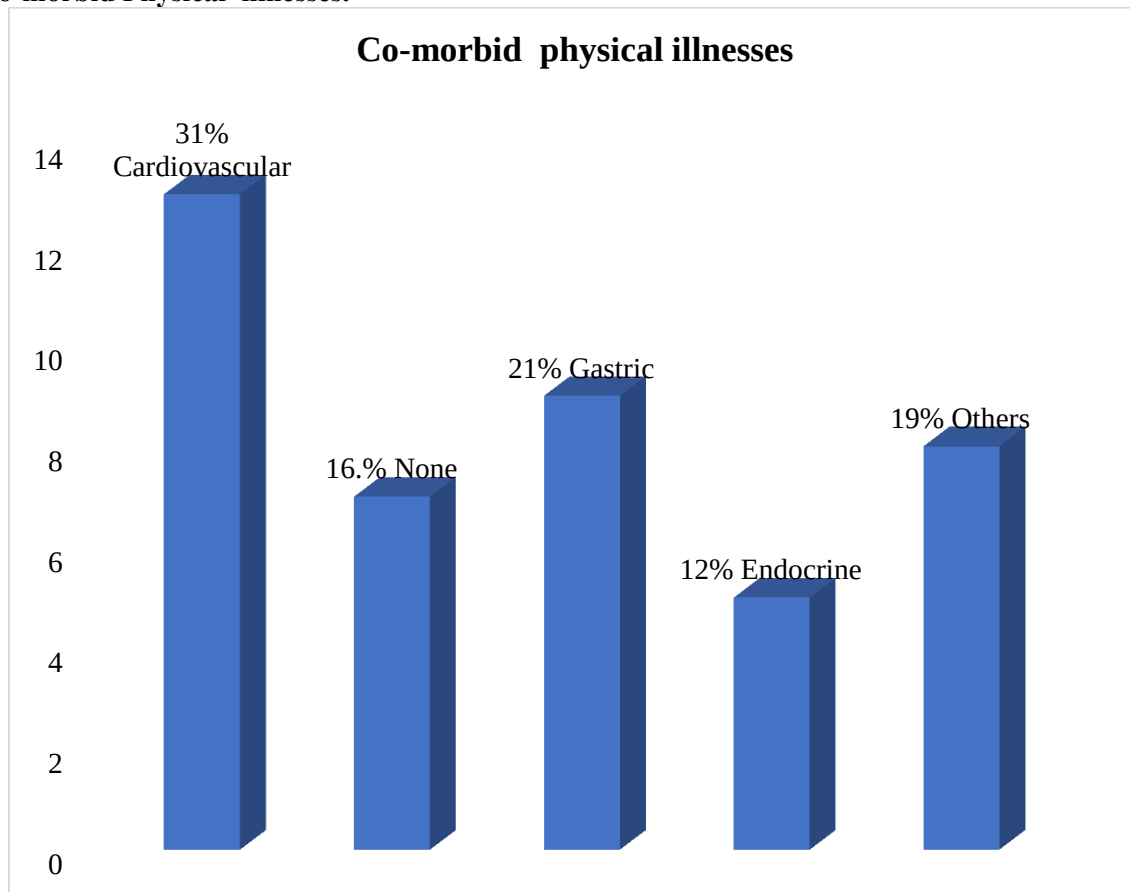


Table 2. Loneliness Assessment Scores.

Variable	Total N	Loneliness UCLA score		Lonely	Not lonely
		N	Mean Score		
Gender					
Male	14	5 6 3	<28 28-43 >43 (21.4%)	21.4%	78.6%
Female	28	12 12 4	<28 28-43 >43 (14.3%)	14.3%	85.7%
Age					
Below 50 years	13	9 3 1	<28 28-43 >43 (7.7%)	7.7%	92.3%
50 -65 years	20	8 7 5	<28 28-43 >43(25%)	25%	75%
Above 65 years	9	6 2 1	<28 28-43 >43(11.1%)	11.1%	88.9%
Marital status					
Single/divorced/widow(er) (=no partner)	10	4 3 3	<28 28-43 >43 (30%)	30%	70%
Married (=have partners)	32	18 9 5	<28 28-43 >43 (15.6%)	15.6%	84.4%

DISCUSSION:

Loneliness is a common phenomenon among psychogeriatric patients in our society with an overall average prevalence of 17.8%. This is less than the result of the study on prevalence of loneliness and its association with depression among retirees in north - central Nigeria, by Igboke and others¹⁸ who found a 21.8% prevalence of loneliness. The difference in prevalence may be because they used the shorter version of the questionnaire UCLA-8 and their sample consisted of only retirees.

Loneliness is a global issue. Nadar and other researchers¹⁹ performed a systematic review and meta analysis of studies on the prevalence of loneliness globally. The lowest prevalence was found in our continent, Africa (15.3%) while the highest prevalence of 30.5% was found in North America. The prevalence of loneliness by continent according to the systematic review and meta analysis of studies is shown in table 3, and the prevalence by setting in table 4.

Table 3. The overall prevalence of loneliness in older adults by continent

Continent	N	Sample size	Prevalence (95% CI)
Europe	47	18,960	27.2(23.9-30.8)
Asia	51	488,811	27.9(25-31)
North America	22	482,421	30.5(24.7-37.0)
South America	2	17,671	18.6 (10.8-30.0)
Africa	2	2,803	15.3(7.2-29.8)
Oceania	6	132,997	25.7 (22.1-29.6)

Table 4. The overall prevalence of loneliness by setting

Setting	N	Sample size	Prevalence (95%CI)
Community dwelling	115	1244326	25.8
Institutionalized	11	5996	50.7

The above tables show that loneliness occurs globally and in all settings with marked variations. For instance, while the continent of Africa has a 15% prevalence of loneliness, North America as a continent has two times more loneliness, with an average prevalence rate of about 30%.

It is worthy to note that while 22 studies were analyzed in North America, in Africa only 2 studies were found and analyzed, indicating that we, African researchers need to do more in this regard.

Reducing feelings of loneliness and enhancing a sense of connectedness and social cohesion are laudable goals because social isolation has a negative impact on overall health. VanderWeele et al. (unpublished) recently examined the reduction in depressive symptoms that could be expected if loneliness were successfully reduced and found there would be significant benefits that would accrue for as long as two years following the intervention. A successful intervention to lower loneliness produced corresponding benefits in physiological mechanisms and health outcomes.

Interventions for loneliness:

A study is relevant to the readers and beneficial to humanity if it provides some ideas on how to prevent, remedy or manage the problem being highlighted by the research. Since 1984, a lot of reviews on interventions on loneliness have been published^{20,21,22}. Most targeted four main types of interventions: (A) enhancing social skills, (B) providing social support, (C) increasing opportunities for social interaction, and (D) addressing maladaptive social cognition.

In our setting in Nigeria, some opportunities exist to enhance the social skills of people as well as enhance their social support which is provided mainly by their families and sometimes by the government, non-

governmental organizations (NGOs) and civil society organizations (CSOs). The psychological services available in our mental health facilities require improvement in terms of facilities and human capital which has been severely affected by the recent “*japa syndrome*” a Nigerian terminology which translates to “brain drain”. Japa syndrome aptly describes the scenario where many health care professionals are leaving Nigeria and Africa to work in other countries abroad. There are limited opportunities for social interaction among the elderly citizens because psychogeriatric services are few and the government currently does not have a policy for setting up services such as old people’s homes. The lack of opportunities for the social interaction can lead to increase in loneliness.

CONCLUSION:

Loneliness is a global social issue, though said to be less common among Africans, is commonly experienced by older adults and the aged. The is a glaring need for more studies on loneliness in Africa.

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REFERENCES:

1. Pinquart M, Sorensen S. Influences on loneliness in older adults: A meta-analysis.

- Basic and Applied Social Psychology. 2001; 23:245–266.
2. Wheeler L, Reis H, Nezlek J. Loneliness, social interaction, and sex roles. *J Pers Soc Psychol*. 1983;45: 943–953.
3. Weeks DJ. A review of loneliness concepts, with particular reference to old age. *International Journal of Geriatric Psychiatry*. 1994; 9:345–355.
4. Russell D, Peplau LA, Cutrona CE. The revised UCLA Loneliness Scale: Concurrent and discriminant validity evidence. *J Pers Soc Psychol*. 1980; 39:472–480.
5. Penninx BW, van Tilburg T, Kriegsman DM, et al. Effects of social support and personal coping resources on mortality in older age: The Longitudinal Aging Study Amsterdam. *Am J Epidemiol*. 1997; 146:510–519
6. Cacioppo JT, Hawkley LC. Perceived social isolation and cognition. *Trends in Cognitive Sciences*. 2009; 13:447–454.
7. DeNiro DA. Perceived alienation in individuals with residual-type schizophrenia. *Issues Ment Health Nurs*. 1995; 16:185–200.
8. Richman NE, Sokolove RL. The experience of aloneness, object representation, and evocative memory in borderline and neurotic patients. *Psychoanalytic Psychology*. 1992; 9:77–91.
9. Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE. *Reducing Suicide: A National Imperative*. Washington, DC: National Academy Press; 2002.
10. Wilson RS, Krueger KR, Arnold SE, et al. Loneliness and risk of Alzheimer disease. *Arch Gen Psychiatry*. 2007; 64:234–240.
11. Cacioppo JT, Hughes ME, Waite LJ, Hawkley LC, Thisted RA. Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging*. 2006; 21:140–151.
12. Berkman, L. F., and S. L. Syme.. Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda county residents. *American Journal of Epidemiology* 1979; 109(2):186–204
13. Steptoe, A., A. Shankar, P. Demakakos, and J. Wardle.. Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences* 2013; 110(15):5797–5801.
14. Koenig, H. G., R. E. Westlund, L. K. George, D. G. Blazer, and C. Hybels.. Abbreviating the Duke Social Support Index for use in chronically ill elderly individuals. *Psychosomatics* 1993; 34(1):61–69.
15. de Jong Gierveld, J., and T. Van Tilburg. A 6-item scale for overall, emotional, and social loneliness: Confirmatory tests on survey data. *Research on Aging* 2006; 28(5):582–598.
16. Russell, D. W. UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of personality assessment*. 1996. 66(1), 20-40.
17. Russel DW, Peplau LA, Ferguson ML; Developing a Measure of Loneliness. *Journal of personality assessment* .1978. 42(3):290-4
18. Igbokwe CC, Ejeh VJ, Agbaje OS, Umoke IC, Iweama CN, Ozoemena EL. Prevalence of loneliness and association with depression and anxiety symptoms among retirees in north central Nigeria: A cross -sectional study. *BMC Geriatrics* 2020; 20:153
19. Nadar salari, Hadi Najafi, Shabnam Rasoulpoor, Zara Canbary, Pegah Heidarian, Masoud Mohammadi. Humanities and social science communication. The global prevalence and associated factors for loneliness in older adults. a systematic review and meta analysis. 2025:12.985.
20. Cattam M, White M. Developing evidence based health promotion for older people: A systematic review and survey of health promotion interventions targeting social isolation and loneliness among older people. *Internet Journal of Health Promotion*. 1998; 13:1–9.
21. Cattam M, White M, Bond J, Learmouth A. Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Aging & Society*. 2005; 25:41–67.
22. Findlay R. Interventions to reduce social isolation amongst older people: Where is the evidence? *Abstracts in Social Gerontology*. 2004:47: 82-5.