

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

Pratiksha Mishra<sup>1\*</sup>

### ABSTRACT

Social connection plays a critical role in mental health and well-being, yet the rising prevalence of social isolation and loneliness among adults poses significant concerns. This study examines the complex interplay between social isolation, loneliness, and depression, integrating qualitative and quantitative research to explore their mechanisms and impact. Social isolation, defined as the lack of meaningful relationships, and loneliness, the subjective feeling of being alone, are shown to contribute to the onset and severity of depression. Findings reveal that chronic loneliness often stems from social isolation, exacerbating depressive symptoms and initiating a cycle of emotional withdrawal. Factors such as age, socioeconomic status, and access to social support systems are identified as moderating variables. The findings underline the need for workplace programs, community-based interventions, and resilience-building initiatives to address the psychological impact of social isolation and loneliness. These insights have profound implications for mental health strategies and policymaking to enhance psychological resilience and well-being. The study also highlights cultural nuances, such as the role of family structures in Indian society, which may provide practical support but fail to alleviate subjective loneliness among young adults.

**Keywords:** *Social connection, social isolation, loneliness, depression, mental health, adults, social support, psychological well-being, interventions*

Humans are inherently social beings, and relationships with others are fundamental determinants of mental health and well-being (Holt-Lunstad et al., 2015). Individuals who experience social disconnectedness or dissatisfaction with their social interactions are at an elevated risk for various psychological disorders. Despite the significant overlap, the constructs of social isolation and loneliness warrant distinct consideration due to their unique contributions to mental health. Social isolation refers to the objective lack of social contact or low frequency of interactions, whereas loneliness is a subjective experience of perceived social disconnection (Cohen, 2004; Hawkey & Cacioppo, 2010).

The prevalence of social isolation and loneliness among adults has grown over recent decades, driven by rapid urbanization, changing family dynamics, and increased reliance on digital communication. These societal and technological shifts have reduced the time spent

<sup>1</sup>MA Counseling Psychology, K.V. Pendharkar College of Arts, Science and Commerce

\*Corresponding Author

Received: January 27, 2025; Revision Received: February 24, 2025; Accepted: February 28, 2025

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

on meaningful face-to-face interactions (Klinenberg, 2018; WHO, 2017). While digital platforms can facilitate connections, they often fail to replicate the emotional depth of in-person interactions. They may even intensify feelings of loneliness in individuals heavily reliant on social media (Primack et al., 2017).

Depression, a leading cause of disability worldwide, is closely linked to chronic loneliness and social isolation (WHO, 2017). Extensive research indicates that insufficient social relationships and persistent loneliness can trigger or exacerbate depressive disorders (Holt-Lunstad et al., 2015; Santini et al., 2020). This relationship is often bidirectional: loneliness can precipitate depressive symptoms, while depression may lead to social withdrawal, deepening isolation, and compounding psychological distress (Perlman & Peplau, 1981; Santini et al., 2020).

Addressing the intricate relationship between social isolation, loneliness, and depression is vital for developing effective interventions. Enhancing social connectedness has been identified as a cornerstone for recovery from major depressive disorders (Cacioppo et al., 2015). Interventions targeting social capital, such as creating communal spaces and fostering group-based activities, have proven effective in mitigating loneliness and improving mental health outcomes (Klinenberg, 2018).

This paper aims to elucidate the intricate relationships between social isolation, loneliness, and depression in adults. By examining these constructs in tandem and exploring their underlying mechanisms, the study seeks to identify actionable intervention points that can foster resilience, enhance social connectedness, and promote a healthier society.

### LITERATURE REVIEW

#### *Social Isolation*

Social isolation, characterized by the absence or infrequency of social interactions, presents a significant risk to mental health, particularly depression. Holt-Lunstad et al. (2015) report a 29% increase in mortality risk associated with social isolation, underscoring its profound impact on mental and physical well-being. Research by Pantell et al. (2013) highlights that loneliness exacerbates chronic conditions such as cardiovascular disease and diabetes while also elevating psychological stress. Similarly, Cacioppo et al. (2015) emphasize the adverse neurological effects of isolation, including diminished stress-coping abilities and heightened susceptibility to depression.

Despite technological advancements that offer alternative means of connection, these solutions often fall short of fostering genuine engagement. Klinenberg (2018) critiques the limitations of digital platforms, asserting that while they may facilitate communication, they frequently fail to cultivate the sense of belonging intrinsic to face-to-face interactions. Primack et al. (2017) support this view, identifying a direct relationship between extensive social media use and increased feelings of loneliness, particularly in individuals reliant on virtual interactions. Further, longitudinal studies by Santini et al. (2020) demonstrate that prolonged social isolation significantly elevates the risk of depressive symptoms, especially among middle-aged adults.

Additionally, the overlap between social isolation and loneliness compounds the risk of depression. Matthews et al. (2019) found that even short-term isolation can negatively impact mental health, with prolonged isolation resulting in severe outcomes such as

## **The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults**

cognitive decline and increased emotional distress. These findings highlight the urgency of addressing social isolation as a public health priority.

### ***Loneliness***

Loneliness, distinct from social isolation, reflects a subjective perception of inadequate interpersonal relationships. Perlman and Peplau (1981) define loneliness as a distressing emotional state arising from perceived social disconnection. Hawkley and Cacioppo (2010) explore the biological underpinnings of loneliness, noting that activation of the hypothalamic-pituitary-adrenal (HPA) axis contributes to elevated stress levels and an increased likelihood of depression. Victor and Yang (2012) further identify loneliness as a predominant factor in mental health challenges across various age groups, particularly young adults and the elderly.

The reciprocal relationship between loneliness and depression is well-documented. Cacioppo et al. (2015) argue that loneliness often triggers withdrawal from social interactions, thereby intensifying feelings of isolation. Cross-sectional studies by Lim et al. (2020) reveal a strong association between loneliness and depressive symptoms, even after controlling for other psychosocial variables. Heinrich and Gullone (2006) extend this understanding by demonstrating that loneliness moderates the relationship between social support and mental health outcomes.

Loneliness has implications beyond mental health. Hawkley et al. (2009) link loneliness to physiological consequences such as elevated blood pressure and poor sleep quality, which exacerbate psychological distress. Community-based interventions, as advocated by Victor et al. (2018), have shown promise in reducing loneliness and enhancing mental well-being through structured social engagement initiatives.

### ***Depression***

Depression, one of the most prevalent mental health disorders globally, is closely intertwined with social isolation and loneliness. The World Health Organization (2017) identifies depression as a leading cause of disability, affecting over 300 million individuals worldwide. Holt-Lunstad et al. (2015) reveal that individuals experiencing social isolation or loneliness are three times more likely to develop depression than their socially connected counterparts. Moreover, Cacioppo et al. (2015) highlight the role of loneliness in both triggering and exacerbating depressive symptoms.

The bidirectional relationship between depression and social factors is critical. Santini et al. (2020) observe that depressive symptoms often lead to avoidance behaviors, further isolating individuals and deepening feelings of loneliness. Matthews et al. (2019) corroborate this, identifying a positive correlation between social isolation and depression, where each reinforces the other. Teo et al. (2013) emphasize that both the quantity and quality of social interactions significantly influence depressive outcomes, with strained relationships heightening the risk of depression.

Psychosocial interventions offer potential solutions. Masi et al. (2011) identify cognitive-behavioral therapy (CBT) as particularly effective in addressing maladaptive cognitions associated with loneliness, thereby reducing depressive symptoms. Klinenberg (2018) advocates for architectural and community-driven approaches to enhance social connectedness, mitigating the adverse effects of isolation on mental health. Similarly,

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

Berkman and Syme (1979) demonstrate the ameliorative impact of strong social networks in reducing depression risk and fostering resilience.

### *Conclusion*

The literature review consistently highlights the interconnected nature of social isolation, loneliness, and depression. These constructs not only influence one another but also create a feedback loop that exacerbates mental health challenges. Addressing these issues requires multifaceted interventions that prioritize both emotional and social dimensions. Strategies focusing on reducing depressive symptoms, enhancing perceived social support, and fostering meaningful connections are essential to alleviating loneliness and promoting psychological well-being. By integrating individual, community, and policy-level initiatives, future efforts can build a more resilient and inclusive society.

## **METHODOLOGY**

This study employed a quantitative, cross-sectional descriptive research design to investigate the relationships between social isolation, loneliness, and depression in adults. The design allowed for the assessment of these variables at a single point in time, facilitating an understanding of their interrelations. Standardized psychometric instruments were utilized to ensure the validity and reliability of the collected data.

### *Sample*

The study sample comprised 150 adults aged 25 to 50 years, recruited from urban communities, workplaces, universities, and public organizations through convenience sampling. Participants were required to meet specific inclusion criteria: fluency in English, willingness to provide informed consent, and the ability to complete the study instruments independently. Exclusion criteria included a history of major psychiatric disorders, significant cognitive impairments, or recent traumatic life events, such as bereavement. These criteria ensured a homogenous sample with minimal external influences.

### *Instruments*

- **Beck Depression Inventory-II (BDI-II):** A 21-item inventory assessing the severity of depressive symptoms over the past two weeks. This widely used tool has demonstrated robust internal consistency (Cronbach's alpha = 0.92).
- **UCLA Loneliness Scale (Version 3):** A 20-item measure evaluating perceived social disconnection and solitude, rated on a 4-point Likert scale. Internal consistency is high, with Cronbach's alpha values ranging from 0.87 to 0.92 across different populations.
- **Multidimensional Perceived Social Support Scale (MPSS):** A 12-item scale measuring perceived support from family, friends, and significant others. Responses are rated on a 7-point Likert scale, with higher scores indicating greater perceived support (Cronbach's alpha = 0.91).

### *Procedure*

Participants were provided with detailed study information and signed informed consent forms before data collection. Assessments were conducted in quiet, comfortable environments to minimize distractions. Each participant completed the study instruments and demographic questionnaire within approximately 30 minutes. Demographic data included age, gender, and educational background, allowing for subgroup analyses.

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

### *Ethical Considerations*

Ethical guidelines were rigorously upheld throughout the study. Participants were thoroughly informed about the purpose, procedures, and potential implications of the research before providing written consent. Confidentiality was maintained by anonymizing responses and securely storing data. Participation was entirely voluntary, and individuals were given the freedom to withdraw at any point without consequence. To address potential distress arising from the assessments, participants were provided with resources for mental health support. Additionally, approval was obtained from the relevant institutional ethics review board to ensure adherence to ethical research practices.

### *Data Analysis*

- **Descriptive Statistics:** Measures of central tendency (mean, median) and variability (standard deviation) summarized demographic and psychometric data.
- **Pearson's Correlation Analysis:** Explored relationships between social isolation (MPSS), loneliness (UCLA Loneliness Scale), and depression (BDI-II).
- **Regression Analysis:** Identified predictive relationships, assessing the contribution of loneliness and social isolation to depressive symptoms.
- **Moderation Analysis:** Examined whether depression moderated the relationship between social isolation and loneliness.

**Table 1. Descriptive statistics for UCLA Loneliness Scale, MSPSS, and BDI-II.**

Scale	N	Mean	Standard Deviation
UCLA	150	51.02	6.96
MSPSS	150	51.44	16.11
BDI 2	150	18.21	16.09

This table presents the mean scores and standard deviations for three psychometric scales: the UCLA Loneliness Scale (perceived loneliness), the MSPSS (social support), and the BDI-II (depressive symptoms) across 150 participants.

This table summarizes the descriptive statistics for three scales: UCLA, MSPSS, and BDI-2. The sample size for each scale is 150 participants. The mean score for the UCLA scale is 51.02, with a standard deviation of 6.96, indicating a moderate spread of scores around the mean. The MSPSS scale has a slightly higher mean score of 51.44, with a greater standard deviation of 16.11, suggesting a wider variability in perceived social support among participants. The BDI-2 scale, which measures depression, shows a mean score of 18.21 and a standard deviation of 16.09, indicating significant variation in depression levels within the sample.

**Table 2. Overall Descriptive Statistics Across All Scales**

Standard deviation	18.86869365
Mean	128.82

This table provides the mean and standard deviation for the overall scores across all measures, reflecting variability in loneliness, social support, and depression levels among the participants.

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

The overall mean score across all measures is 128.82, with a standard deviation of 18.87. This reflects the general level of the variables measured and the variability in participants' responses. The relatively high standard deviation suggests a diverse range of scores among the participants.

**Table 3. Age Distribution of Participants: Socio-Demographic Characteristics**

	<b>N</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Standard deviation</b>
<b>Age</b>	150	18	58	23.94	5.782998069
<b>Valid list</b>	150				

The participants' ages range from 18 to 58 years, with a mean age of 23.94 years and a standard deviation of 5.78. This indicates that most participants are young adults, as evidenced by the mean age close to 24 years.

**Table 4. Age Group Distribution of Participants**

<b>Age</b>	<b>Count</b>	<b>Percentage</b>
18 - 24	108	72
25 - 31	28	18.7
32 - 38	8	5.3
39 - 45	4	2.7
46 - 52	1	0.7
53 - 59	1	0.7
<b>Total</b>	<b>150</b>	<b>100</b>

This table shows the frequency and percentage distribution of participants across six age groups, highlighting the predominance of individuals aged 18–24 years (72%).

The majority of participants (72%) fall into the age group of 18-24 years, followed by 18.7% in the 25-31 age group. Smaller proportions of participants belong to older age groups, with only 0.7% each in the 46-52 and 53-59 age brackets. This indicates that the sample is predominantly composed of younger individuals, with very few older participants.

**Table 5. Gender Distribution of Participants**

		<b>Mean</b>	<b>Count</b>	<b>Colum</b>
<b>Gender</b>	Male		47	31.33%
	Female	24	103	68.67%

The gender distribution shows that 68.67% of the participants are female (103 individuals), while 31.33% are male (47 individuals). This highlights a higher representation of females in the sample, suggesting a gender imbalance.

**The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults**

**Table 6. Demographic Characteristics of the participant regarding the distribution of living Status.**

		Count	Colum
<b>Living Situation</b>	<b>Alone</b>	<b>8</b>	<b>5.33%</b>
	<b>With roommates</b>	<b>28</b>	<b>18.67%</b>
	<b>With Family</b>	<b>114</b>	<b>76</b>

This table highlights the living situations of the participants. The majority (76%, 114 participants) live with their families, while 18.67% (28 participants) reside with roommates. Only a small proportion (5.33%, 8 participants) live alone. This indicates that most participants maintain a family-based living arrangement, which could potentially influence their levels of social support, loneliness, and depression.

**Table 7. Pearson Correlation Analysis**

Scale		N	r Value	p-value
Social isolation	Pearson correlation	150	-0.06009601065	0.465
Loneliness				
Social isolation	Person Correlation	150	0.2498135432	0.00205
Depression				
loneliness	Pearson correlation	150	-0.5754152172	0.00**
depression				

**This table examines the correlations between social isolation, loneliness, and depression:**

- Social Isolation and Loneliness: A negligible negative correlation ( $r = -0.061$ ,  $p = 0.465$ ) indicates no significant relationship between these variables.
- Social Isolation and Depression: A positive, moderate correlation ( $r = 0.25$ ,  $p = 0.002$ ) suggests that higher social isolation is associated with increased levels of depression.
- Loneliness and Depression: A strong negative correlation ( $r = -0.575$ ,  $p = 0.00$ ) highlights that as loneliness decreases, depression also tends to decrease. This finding is statistically significant, indicating a meaningful relationship.

**Table 8. Multiple Regression Analysis**

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>0</b>		coef	std err	t	P> t
<b>1</b>	const	48.1626	2.625	18.344	0.000
<b>2</b>	MSPSS	0.0072	0.041	0.176	0.861
<b>3</b>	BDI	0.1366	0.039	3.509	0.001

This analysis tests the main hypothesis: how social isolation (MSPSS) and depression (BDI) impact loneliness (UCLA).

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

The following results are notable:

- The constant (intercept) is significant ( $p < 0.001$ ), suggesting a strong baseline level of loneliness in the population.
- The MSPSS coefficient (0.0072,  $p = 0.861$ ) is not statistically significant, indicating that social isolation alone does not strongly predict loneliness.
- The BDI coefficient (0.1366,  $p = 0.001$ ) is significant, demonstrating that depression significantly contributes to loneliness.
- Thus, depression plays a more critical role in explaining loneliness compared to social isolation.

**Table 9. Moderation Analysis:**

	0	1	2	3	4	5	6
0		coef	std err	t	$P >  t $	[0.025	0.975]
1	const	52.9761	3.431	15.439	0.000	46.194	59.758
2	MSPSS	-0.0834	0.058	-1.427	0.156	-0.199	0.032
3	BDI	-0.0270	0.085	-0.316	0.753	-0.196	0.142
4	Interaction	0.0036	0.002	2.143	0.034	0.000	0.007

This analysis examines whether depression (BDI) moderates the relationship between social isolation (MSPSS) and loneliness (UCLA). Key findings include:

- The main effects of MSPSS and BDI are not significant ( $p = 0.156$  and  $p = 0.753$ , respectively).
- The interaction term (0.0036,  $p = 0.034$ ) is significant, indicating that depression moderates the relationship between social isolation and loneliness. Specifically, the interaction shows that the effect of social isolation on loneliness changes depending on the level of depression.

### Findings

#### Descriptive Statistics

- **UCLA Loneliness Scale:** The mean score of 51.02 ( $SD = 6.96$ ) reflects moderate levels of loneliness among participants, with relatively low variability. This suggests that feelings of loneliness are a common experience within the sampled group.
- **Multidimensional Perceived Social Support Scale (MPSS):** A mean score of 51.44 ( $SD = 16.11$ ) indicates moderate perceived social support, but the higher standard deviation points to significant variability in participants' experiences of support. This variation could reflect differing social structures or cultural norms within the sample.
- **Beck Depression Inventory-II (BDI-II):** The mean score of 18.21 ( $SD = 16.09$ ) highlights substantial variability in depressive symptoms. Some participants likely experienced minimal symptoms, while others faced severe depression, underscoring the heterogeneity of the sample.

#### Correlation Analysis

- **Social Isolation and Loneliness:** The negligible correlation ( $r = -0.060$ ,  $p = 0.465$ ) suggests that these constructs, while related, are distinct. Social isolation represents

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

an objective lack of connections, whereas loneliness is shaped by subjective perceptions.

- **Social Isolation and Depression:** A moderate positive correlation ( $r = 0.250$ ,  $p = 0.002$ ) indicates that increased social isolation is associated with higher levels of depressive symptoms. This aligns with prior research emphasizing the psychological toll of prolonged isolation.
- **Loneliness and Depression:** A strong negative correlation ( $r = -0.575$ ,  $p < 0.001$ ) demonstrates a significant relationship between reduced loneliness and decreased depressive symptoms. This underscores the profound emotional impact of loneliness on mental health.

### *Socio-Demographic Characteristics*

- The sample predominantly consisted of **young adults (mean age = 23.94 years, SD = 5.78)**, with 72% of participants aged 18–24.
- Gender distribution showed a higher representation of **females (68.67%)** compared to males (31.33%).
- Most participants (76%) lived with their families, 18.67% with roommates, and only 5.33% lived alone.

### *Regression and Moderation Analysis*

- **Regression Analysis:** Depression (BDI-II) emerged as a significant predictor of loneliness ( $p = 0.001$ ). In contrast, social isolation (MPSS) did not significantly predict loneliness ( $p = 0.861$ ), reinforcing the subjective nature of loneliness.
- **Moderation Analysis:** Depression significantly moderated the relationship between social isolation and loneliness (interaction term:  $p = 0.034$ ). This finding highlights that individual with higher levels of depression experience amplified loneliness even in socially isolated conditions.

## **DISCUSSION**

The findings of this study emphasize the intricate dynamics linking social isolation, loneliness, and depression. Depression emerged as a significant predictor of loneliness, suggesting that emotional and psychological factors may outweigh objective measures of social isolation in determining subjective experiences of loneliness. This aligns with previous research highlighting the profound psychological burden of depression, which can amplify feelings of disconnection and hinder social engagement (Cacioppo et al., 2015; Santini et al., 2020). This indicates the need for targeted mental health interventions, such as workplace counseling programs or college-based peer support groups, to address depressive symptoms before they escalate into chronic loneliness. For instance, providing resilience training workshops or integrating mindfulness practices in work and academic settings could empower individuals to combat depressive thoughts and feelings of isolation.

Interestingly, the lack of a strong correlation between social isolation and loneliness reinforces the distinction between these constructs. While social isolation represents an objective absence of social interactions, loneliness is inherently subjective and influenced by individual perceptions, emotional resilience, and social expectations. The significant moderation effect of depression underscores its pivotal role in intensifying the impact of social isolation on loneliness, suggesting that addressing depressive symptoms could mitigate the adverse effects of social isolation.

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

Demographic insights further contextualize these findings. The sample's predominance of young adults living with family underscores the complex interplay of cultural and societal norms, which may provide objective support structures yet fail to alleviate subjective loneliness. In Indian culture, where family is traditionally considered a strong source of emotional and social support, this finding highlights an emerging paradox. While family structures may provide physical proximity and practical help, they may not address the deeper emotional needs of younger adults, especially in urban areas where generational gaps in communication are common. Culturally tailored interventions are necessary to address the unique challenges faced by individuals in family-based living situations. For example, structured family counseling sessions or community-based mental health programs could help families better understand and address the emotional needs of their members, especially in urban Indian contexts. Additionally, the significant variability in depressive symptoms points to the need for tailored interventions that account for individual differences in emotional and social experiences.

In the above-mentioned findings, we also see that the gender distribution showed a higher representation of females (68.67%) compared to males (31.33%). This gender imbalance reflects broader societal patterns in India, where women are often more likely than men to participate in research studies due to differing perceptions of emotional vulnerability and willingness to discuss mental health. Future interventions could address male underrepresentation in mental health initiatives by normalizing emotional expression and offering gender-sensitive support systems.

### *Further Suggestions*

#### **Targeted Interventions**

- **Focus on Depression Reduction:** Educational institutions and workplaces could introduce resilience-building workshops that focus on strengthening coping skills and emotional well-being. For example, programs like 'Stress Management for Young Adults' could help individuals reframe maladaptive thoughts. Similarly, employers could offer subsidized CBT sessions to employees dealing with stress, loneliness, or depression.
- **Enhance Emotional Resilience:** Incorporate resilience training into mental health programs to improve coping mechanisms and reduce vulnerability to loneliness and depressive symptoms.

#### **Strengthening Social Support**

- **Quality Over Quantity:** Develop initiatives that emphasize the depth and quality of social interactions, such as peer support groups and mentorship programs.
- **Community-Based Programs:** Foster meaningful connections through group activities, volunteer opportunities, and community engagement events. In the Indian context, community-based interventions could leverage existing cultural traditions, such as festivals, religious gatherings, or neighborhood committees, to encourage meaningful interactions. For instance, organizing mental health awareness campaigns during festivals like Diwali or Navratri could integrate emotional well-being into culturally significant activities.

## The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults

### *Holistic Mental Health Strategies*

- **Integrated Approaches:** Design programs that address both emotional well-being and social connectedness, recognizing their interdependence.
- **Architectural and Urban Planning:** Create public spaces that encourage face-to-face interactions and communal activities. For instance, designing community parks with seating areas that promote conversation, or hosting weekly outdoor activities like yoga or cultural events, could encourage meaningful social interactions. Similarly, urban housing societies could introduce shared spaces, such as libraries or rooftop gardens, to facilitate informal connections among residents.

### *Future Research*

- **Longitudinal Studies:** Conduct studies to explore the causal relationships between social isolation, loneliness, and depression over time.
- **Diverse Populations:** Expand research to include rural populations, older adults, and individuals from varied cultural and socioeconomic backgrounds to enhance generalizability.

## CONCLUSION

The findings underscore the complex interplay between social isolation, loneliness, and depression. Depression emerged as a significant predictor of loneliness, while the moderating effect of depression highlights its role in intensifying the impact of social isolation. Addressing these dynamics requires holistic interventions that target both emotional and social dimensions to mitigate loneliness and enhance psychological well-being. By leveraging India's rich cultural traditions and emphasizing family and community support systems, these findings can inform interventions that address loneliness and depression in a culturally sensitive manner. Future research should expand on these findings through longitudinal designs and diverse samples to inform inclusive mental health strategies.

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### **Acknowledgment**

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

### **Conflict of Interest**

The author(s) declared no conflict of interest.

**How to cite this article:** Mishra, P. (2025). The Power of Social Connection: The Relationship Between Loneliness, Social Isolation and Depression in Adults. *International Journal of Indian Psychology*, 13(1), 1361–1372. DIP:18.01.130.20251301, DOI:10.25215/1301.130