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ISOLATION OF ELDERLY WOMEN IN INDIA: A STRUCTURED LITERATURE REVIEW

Abujam Sanatomba Singh

RESEARCH ARTICLE

Author Details:
Assistant Professor, Department of Sociology, D.M. College of Arts. Dhanamanjuri University

Corresponding Author:
Abujam Sanatomba Singh

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Abstract

Social isolation and loneliness among elderly women in India constitute a growing, gendered public health challenge shaped by demographic ageing, widowhood, socio-economic disadvantage, and changing family structures. This structured literature reviews recent evidence (2015–2026), including systematic reviews and analyses of the Longitudinal Ageing Study in India (LASI), to map prevalence, determinants, and gaps specific to older women. Findings indicate wide but consistently elevated estimates: loneliness ranges from roughly 4% to over 60% and social isolation up to 86% across studies, with women reporting higher levels than men (e.g., ~17.5% vs ~12% in LASI-based work). Widowhood emerges as a central pathway into isolation, compounded by higher likelihood of living alone, limited income or property rights, reduced social participation, and persistent stigma. Individual correlates include chronic illness, functional limitations, depression/anxiety, and small social networks; household and structural drivers include migration of adult children, urbanisation, and erosion of joint-family support. Rural residence, low education, and experiences of abuse further exacerbate vulnerability. Methodological heterogeneity in measurement and under-representation of marginalised subgroups (e.g., widows in religious towns, women in slums, institutionalised elders) limit precise prevalence estimates and policy targeting. The review underscores the need for gender-sensitive interventions—community engagement, physical and social activity programmes, legal-financial empowerment, and caregiver support—alongside improved surveillance using standardised tools. Addressing isolation among elderly women requires integrating mental health, social protection, and ageing policies within India's broader "feminisation of ageing" agenda.

Keywords: *elderly women; social isolation; loneliness; widowhood*

Introduction

India's population is ageing rapidly. The number of Indians aged 60 and above, close to 100 million in 2011, is projected to reach 230 million by 2036, with several states — Kerala, Tamil Nadu, and Himachal Pradesh among them — expected to have more than a fifth of their population in this age group (Muralidharan et al., 2026). This demographic shift is accompanied by a well-documented "feminisation of ageing": women live longer than men on average, form the majority of the very old, and disproportionately experience widowhood, illiteracy, and economic dependency in later life (Kumar & Bhargava, 2014). Against this backdrop, social isolation and loneliness among older adults — and among older women in particular — have emerged as pressing but under-examined public health and social concerns in India.

Rapid urbanisation, migration of working-age children, and the gradual replacement of joint family systems by nuclear households have repeatedly been identified as structural drivers of isolation among India's elderly (Farid et al., 2014; Kumar & Bhargava, 2014; Vishwakarma et al., 2023). Because women in India have historically had lower rates of education, asset ownership, and independent income than men, the erosion of the joint family safety net tends to affect them differently and, in several respects, more severely (Farid et al., 2014; Kumar & Bhargava, 2014). Yet very few empirical studies isolate women as a distinct analytic population; gender more typically appears as one covariate among several socio-demographic variables.

This review synthesises nine sources — eight empirical studies and one systematic review — published between 2014 and 2026, spanning community, clinical, and institutional settings across India (with one comparative India–Thailand study). It draws out what is known specifically about the isolation of elderly women in India by extracting gender-disaggregated findings wherever they are reported, while also situating these findings within the broader literature on ageing, loneliness, depression, and elder abuse in the Indian context. The review is organised into five sections: key theoretical perspectives, major themes, commonly used methods, important findings, and finally the limitations and unanswered questions that define the frontier of this field.

Key Theoretical Perspectives

A recurring theoretical move in this literature is the careful separation of "social isolation" from "loneliness." Social isolation is treated as an objective, structural condition — "a state where individuals have minimal contacts and paucity of social relationships and social engagements" — while loneliness is a subjective discrepancy between an individual's desired and achieved level of social contact (Mishra et al., 2023). Farid et al. (2014) draw the same distinction, tracing loneliness to the phenomenological accounts of Fromm-Reichmann and Perlman and Peplau, and social isolation to more structural, network-based definitions such as Lubben and Gironda's. Farid et al. (2014) add a third, frequently conflated construct — social exclusion — defined as the structural denial of developmental benefits to particular social groups on the basis of identity markers such as gender, caste, or religion. This three-way conceptual distinction matters for the present review because it clarifies that an elderly woman may be socially isolated (few contacts) without being lonely (if her expectations of contact are low), or lonely without being objectively isolated (if the quality, not quantity, of her relationships is deficient).

A second theoretical strand concerns psychological well-being. Mishra et al. (2023) operationalise well-being using Ryff and Keyes's six-dimensional model — autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance — and complement it with Seligman's PERMA framework, which positions engagement and relationships as central pillars of flourishing. Within this framework, isolation and loneliness are theorised not merely as risk factors for depression but as direct threats to the structural preconditions of a psychologically "good life" in old age.

A third strand is essentially demographic-structural: the transition from joint to nuclear family systems is treated, across several sources, as the master explanatory variable behind rising isolation. Vishwakarma et al. (2023) frame this as a consequence of economic and technological development forcing rapid industrialisation, migration for education and jobs, and the fragmentation of ancestral households. Kumar & Bhargava (2014) similarly root elder abuse and neglect in the "breakdown of the joint family structure, which used to be the primary support for the elderly in India," linking this to urbanisation, women's increasing (if still limited) workforce participation, and the growth of individualism. Farid et al. (2014) operationalise this structural account at the level of gendered household roles, arguing that Pakistani (and, by extension, South Asian) men are traditionally positioned as the family's economic providers while women are positioned as custodians of domestic and relational life — a division of labour whose collapse in old age produces isolation through different causal pathways for each gender.

A fourth, more applied theoretical contribution comes from Aroonsrimorakot et al. (2022), who use a grounded-theory approach — inductively building explanatory categories from in-depth interview data rather than testing a pre-specified hypothesis — to derive a four-part intervention framework (social facilitation, community approach, productive engagement, and health and social care) for reducing isolation among the "oldest old" in India and Thailand. This bottom-up theorising complements the top-down, deductive hypothesis-testing that characterises most of the quantitative literature reviewed here.

Finally, an implicit theory of gendered vulnerability runs through several sources without being fully formalised. Kumar & Bhargava (2014) note that approximately 30 per cent of elderly men in India possess no valuable assets, compared with 60 per cent of elderly women — a figure they connect to lifelong patterns of exclusion from education, employment, and property ownership that leave women financially dependent first on husbands and later on sons. This "cumulative disadvantage" logic, though not named as such in the source, underlies much of what this review identifies below as the gendered dimension of isolation.

Major Themes

The Co-occurrence and Conceptual Overlap of Isolation and Loneliness

Several studies confirm that social isolation and loneliness, while conceptually distinct, are empirically intertwined. Mishra et al. (2023) found a significant negative correlation between social isolation and loneliness scores among 320 residents of Indian old-age homes ($r = –.505$, $p < .01$), and a regression model in which social isolation significantly predicted loneliness, explaining 25.6 per cent of the variance. At the review level, Muralidharan et al. (2026) found that, across the Indian literature as a whole, reported loneliness prevalence ranges enormously — from 3.8 to 66.4 per cent across eleven studies — while social isolation prevalence ranges from 3.6 to 86.4 per cent across four studies, a heterogeneity the authors attribute to inconsistent scales and cut-off points rather than genuine population differences.

Gendered Dimensions of Isolation

The clearest gender-specific finding in this literature comes from Farid et al. (2014), whose South Asian family-based study found that lack of money was the strongest statistical predictor of isolation among aged men (regression equation: isolation = 6.97 + 1.007 × lack-of-money score, $p < .001$), whereas lack of involvement in family issues and decision-making was the strongest predictor among aged women (isolation = 33.80 + 0.19 × lack-of-involvement score, $p < .001$). Female respondents in that study were considerably less likely to cite money as an isolating factor (41.7% strongly disagreed that lack of money isolated them) but were far more likely to cite exclusion from family decision-making (46% strongly agreed). The authors interpret this as reflecting a gendered division of roles in which men's social value is tied to their role as economic providers and women's is tied to their role within domestic and relational life; when either role collapses in old age, isolation follows, but via different mechanisms for each sex.

Vijayshri and Farooqi (2014), studying 320 older adults in Delhi, found a strikingly similar gender split in the loneliness–depression relationship: among female elderly, loneliness and depression were positively correlated ($r = .562$, $p < .01$), whereas among male elderly the correlation was negative ($r = –.546$, $p < .01$), meaning depressive symptoms among men tended to decrease as loneliness increased. Women in this sample were also significantly more depressed than men overall (mean Beck

Depression Inventory score 30.70 versus 25.03, $p < .01$), a pattern the authors attribute to being "more emotional" and to gender-specific stressors such as spousal death, financial dependency, lack of education, unemployment, and estrangement from family. Kumar and Bhargava (2014), synthesising newspaper reports on elder abuse, report that older women are predominantly at risk of financial, physical, and sexual abuse, and cite a HelpAge India survey in which 52 per cent of abused elders were women compared with 48 per cent men. The same source documents a case of an 81-year-old woman raped in Delhi and notes that Indian society continues to discourage the remarriage of widows far more strongly than that of widowers, compounding the isolation that follows spousal loss for women specifically.

Not every study, however, found gender to operate as expected. Mishra et al. (2023) formally tested gender as a mediator of the relationship between isolation/loneliness and psychological well-being among old-age home residents and found the indirect effects non-significant for both isolation ($\beta = .012$, $p > .05$) and loneliness ($\beta = –.003$, $p > .05$) — meaning that, once isolation and loneliness are present, their negative impact on well-being does not differ significantly by gender, even though the baseline exposure to isolating conditions may differ. The authors note this diverges from earlier work (Matud et al., 2020, as cited in Mishra et al., 2023) suggesting men report better psychological well-being on dimensions such as self-acceptance and autonomy. Duraisamy et al. (2026), by contrast, found female gender significantly associated with financial dependence (odds ratio 2.83, 95% CI 1.95–4.12) though not with loneliness or social isolation per se in their rural Tamil Nadu sample — suggesting that gender may shape specific pathways (financial dependency) more consistently than it shapes isolation or loneliness outcomes directly.

Family Structure, Living Arrangements, and Marital Status

The transition from joint to nuclear family living is treated across the literature as a central driver of isolation. Vishwakarma et al. (2023) describe how industrialisation, national population-control programmes, and youth migration for education and employment have fragmented joint households, leaving elderly parents "abandoned in their ancestral homes with little physical, psychological, emotional, financial, or social care." Duraisamy et al. (2026) found that 84 per cent of their rural South Indian sample already lived in nuclear rather than joint families, a context within which financial dependency, isolation, and loneliness co-occurred as a "triple burden."

Living arrangement and marital status interact in complex, sometimes counter-intuitive ways. Vijayshri and Farooqi (2014) found that elderly people living alone reported significantly higher loneliness than those living with family (mean UCLA score 47.66 versus 43.20, $p < .01$), yet depression scores were significantly higher among those living with family (mean 30.71 versus 25.02, $p < .01$) — a pattern the authors attribute to intergenerational communication gaps, misunderstandings, and the burden of unmet expectations that can arise even within a shared household. Mehra et al. (2024) similarly found that loneliness was significantly higher among elderly people who were single (widowed, divorced, or never married) than among the married, and significantly higher among those in nuclear family setups than in joint or extended families. Farid et al. (2014) report that widowhood was the single most common marital status among socially isolated women in their sample (46.6%, compared with 36.6% among isolated men), and that being unmarried or divorced was itself a significant contributing factor to isolation for both sexes. Mishra et al. (2023) add nuance by showing that marital status only partially mediates the impact of isolation and loneliness on well-being, and that for institutionalised elders, being married is not automatically protective if the spouse does not co-reside — a finding consistent with Hank and Wagner's (2013, as cited in Mishra et al., 2023) argument that marital status protects well-being only when it is characterised by ongoing reciprocity.

Financial Dependency and Economic Vulnerability

Financial dependency emerges repeatedly as both a cause and a consequence of isolation, and as a domain in which gender differences are unusually consistent. Duraisamy et al. (2026) frame financial dependency, social isolation, and loneliness as a mutually reinforcing "triple burden," reporting that 56.4 per cent of their rural sample (aged 50 and above, $n = 500$) were financially dependent on family members, with dependency significantly associated with older age (odds ratio 2.22), female gender (odds ratio 2.83), lower socio-economic status (odds ratio 1.96), and tobacco use (odds ratio 1.84). Farid et al. (2014) found lack of money to be the dominant predictor of isolation among men but not among women, for whom relational exclusion mattered more — a finding that, read alongside Duraisamy et al. (2026), suggests women are more likely to be financially dependent in the first place but experience the isolating consequences of that dependency somewhat differently than men experience outright poverty. Kumar and Bhargava (2014) document financial and "identity theft" abuse of elderly people, especially women, including cases of caregivers or relatives draining bank accounts, misusing pensions, and exploiting the trust of isolated elders who depend on them for basic transactions.

Elder Abuse, Neglect, and Caregiver Relationships

Elder abuse is both a correlate and a driver of isolation and loneliness in this literature. Kumar and Bhargava (2014), analysing sixteen newspaper articles through content analysis, identify verbal abuse (41%), disrespect (33%), and neglect (29%) as the most commonly reported forms of mistreatment, alongside physical and financial abuse; they cite HelpAge India survey data indicating that roughly half of India's elderly experience some form of abuse, with women more affected than men (52% versus 48%). Mehra et al. (2024), using the Caregiver Abuse Screen (CASE) in a rural Haryana sample, found that 43.2 per cent of elderly participants reported caregiver abuse — 37.6 per cent involving physical or psychological abuse and 35.2 per cent involving neglect — and that caregiver abuse was the strongest single predictor of loneliness in a multivariable regression model, ahead of family income and depression severity. Muralidharan et al. (2026), synthesising the wider literature, likewise identify elder abuse (odds ratio 1.91, drawing on Pengpid and Peltzer's 2021 LASI-based analysis) as a significant risk factor for loneliness at the national level. Legal protections exist — the Maintenance and Welfare of Parents and Senior Citizens Act, 2007

obliges children to provide for parents' food, shelter, clothing, and medical needs, with penalties including imprisonment or fines for non-compliance (Mishra et al., 2023; Kumar & Bhargava, 2014) — but both sources note that implementation remains weak and inconsistent.

Physical and Mental Health Correlates

Depression and, to a lesser extent, somatisation are the most thoroughly documented health correlates of isolation and loneliness. Vishwakarma et al. (2023), reviewing thirty-five studies, report Indian community-based depression prevalence estimates ranging from roughly 17 per cent to nearly 85 per cent depending on setting, scale, and cut-off, and identify old age, economic dependence, co-morbidity, nuclear family living, low income, illiteracy, and gender (with women more susceptible, partly attributed to hormonal changes around menopause and to widowhood) as recurring risk factors. Mehra et al. (2024) found that among rural elderly with a 66.4 per cent prevalence of loneliness, higher loneliness scores were significantly associated with greater depression severity (Geriatric Depression Scale), somatisation (Patient Health Questionnaire-15), and caregiver abuse, together explaining roughly 21 per cent of the variance in loneliness in a linear regression model. Vijayshri and Farooqi (2014) similarly found an overall positive correlation between loneliness and depression ($r = .216$, $p < .01$), though, as noted above, this relationship was moderated by both living arrangement and gender. Mishra et al. (2023) demonstrated that high isolation combined with high loneliness was associated with the lowest scores on every dimension of psychological well-being except environmental mastery, while low isolation combined with low loneliness was associated with the best outcomes — directly linking the two exposure variables to a broad, multidimensional measure of flourishing rather than to depression alone.

Institutional Care Versus Family and Community Settings

Isolation appears markedly more severe within institutional settings than in general community samples. Mishra et al. (2023), studying 320 residents of old-age homes across India, found 84.38 per cent were socially isolated and 86.88 per cent reported loneliness — far higher than most community-based estimates reviewed elsewhere in this literature. The authors situate this within India's regulatory landscape: as of 2022 there were 502 government-supported old-age homes operating under the Integrated Programme for Senior Citizens, subject to minimum standards for space, food, and medical care, yet residents' relocation is typically involuntary and driven by family breakdown, illness, or financial insecurity, which itself compounds isolation. Aroonsrimorakot et al. (2022) complement this with qualitative evidence from both institutional (Panchvati Home, Delhi; Baan Bangkhae, Thailand) and community settings in Manipur and Thailand, finding that even community-dwelling elders aged 80 and above frequently described restricted mobility, loss of a spouse, and reduced social contact as central to their experience of loneliness, while those still embedded in extended family and community networks — including through religious and socio-cultural activities — reported greater peace of mind. Farid et al. (2014) make the useful methodological point of deliberately excluding institutionalised elders from their sample on the grounds that such elders are "already isolated" by definition, thereby focusing attention on the less visible phenomenon of isolation occurring within an ostensibly intact family home — the specific phenomenon their title names.

Regional and Rural–Urban Variation

The reviewed studies span a wide range of Indian states and settings, and prevalence estimates vary accordingly. Mehra et al. (2024) report the highest single-study loneliness prevalence in this review (66.4%) from a rural Haryana clinic population; Duraisamy et al. (2026) report a triple-burden profile (53.2% loneliness, 63.2% isolation, 56.4% financial dependency) from rural Tamil Nadu; Vijayshri and Farooqi (2014) draw on an urban Delhi sample; Kumar and Bhargava (2014) analyse newspaper reports concentrated in metropolitan centres such as Delhi, Bangalore, and Nagpur; and Aroonsrimorakot et al. (2022) offer a rare qualitative case study from Imphal, Manipur, in India's northeast — a region markedly under-represented elsewhere in this literature. Muralidharan et al. (2026), synthesising twenty studies spanning states including Tamil Nadu, Punjab, Chhattisgarh, Maharashtra, Haryana, and Karnataka, conclude that this state-level and methodological heterogeneity, rather than genuine differences in underlying burden, likely explains much of the wide prevalence range observed nationally.

Commonly Used Methods

The methodological toolkit of this literature is dominated by cross-sectional survey designs. Of the nine sources reviewed, seven are cross-sectional quantitative studies (Mishra et al., 2023; Vijayshri & Farooqi, 2014; Farid et al., 2014; Duraisamy et al., 2026; Mehra et al., 2024; Kumar & Bhargava, 2014, which additionally relies on newspaper content analysis; and Vishwakarma et al., 2023, a narrative literature review). Aroonsrimorakot et al. (2022) is a qualitative, mixed-methods grounded-theory study built on 24 semi-structured, in-depth interviews with elders aged 80 and above plus key-informant interviews with care-home administrators. Muralidharan et al. (2026) is a formal systematic review, registered with PROSPERO and reported according to PRISMA guidelines, that screened 894 records down to 20 included studies.

Standardised psychometric instruments recur across the primary studies. The UCLA Loneliness Scale, in its original or short/revised forms, is the single most widely used loneliness measure, appearing in Mishra et al. (2023), Vijayshri and Farooqi (2014), and Mehra et al. (2024), and identified by Muralidharan et al. (2026) as the dominant validated instrument across the broader Indian literature. The Lubben Social Network Scale-6 is used to measure social isolation in Mishra et al. (2023) and Duraisamy et al. (2026), and is likewise flagged by Muralidharan et al. (2026) as one of the two standard isolation measures in use nationally (alongside social-exclusion indicator sets and ad hoc questionnaires). Depression is most often measured with the Geriatric Depression Scale (Mehra et al., 2024; discussed at length in Vishwakarma et al., 2023) or the Beck Depression Inventory-II (Vijayshri & Farooqi, 2014); somatisation is measured with the Patient Health Questionnaire-15 (Mehra et al., 2024); psychological well-being is measured with the shortened 42-item Ryff and Keyes scale (Mishra et al., 2023); financial

dependency is measured with the WHO Study on Global AGEing and Adult Health (SAGE) two-item measure (Duraisamy et al., 2026); and caregiver abuse is measured with the Caregiver Abuse Screen (Mehra et al., 2024).

Sampling strategies vary by study purpose. Mishra et al. (2023) used purposive sampling of old-age-home residents, explicitly excluding those with diagnosed dementia, schizophrenia, or terminal illness. Duraisamy et al. (2026) used multi-stage random sampling of villages and then households. Vijayshri and Farooqi (2014) used random sampling within Delhi housing societies. Farid et al. (2014) used a two-phase mixed design, first screening 385 respondents for self-perceived isolation via interview, then administering a structured questionnaire to the 120 who identified as isolated. Aroonsrimorakot et al. (2022) used purposive convenience sampling, a common approach in qualitative gerontological research where the goal is thematic saturation rather than statistical representativeness. Analytically, the literature draws on Pearson correlation and independent-samples t-tests (Vijayshri & Farooqi, 2014), MANOVA and formal mediation/path analysis (Mishra et al., 2023), linear and logistic regression (Farid et al., 2014; Duraisamy et al., 2026; Mehra et al., 2024), chi-square tests (Duraisamy et al., 2026), thematic and content analysis of qualitative or textual data (Kumar & Bhargava, 2014; Aroonsrimorakot et al., 2022), and, in the systematic review, Newcastle-Ottawa risk-of-bias assessment with an abandoned meta-analysis (I^2 = 99%) replaced by narrative synthesis (Muralidharan et al., 2026).

Finally, several primary studies embedded in the wider literature synthesised by Muralidharan et al. (2026) draw on large national or multi-country datasets — the Longitudinal Ageing Study in India (LASI), the WHO Study on Global AGEing and Adult Health (SAGE), and the Building Knowledge base on Population Ageing in India (BKPAI) project — which offer far larger and more representative samples (in the tens of thousands) than any single primary study reviewed here directly, though even these differ in their operational definitions of loneliness, limiting comparability.

Important Findings

Taken together, the nine sources support several convergent conclusions. First, loneliness and social isolation are both highly prevalent among India's elderly, though estimates vary enormously by setting and instrument: community-based prevalence of loneliness ranges from under 4 per cent to over 66 per cent across studies (Muralidharan et al., 2026), with the national Longitudinal Ageing Study in India estimating 13.4 per cent (cited in Muralidharan et al., 2026), rural clinic-based samples reporting far higher rates around 66 per cent (Mehra et al., 2024), and institutionalised populations showing the highest rates of all, at roughly 87 per cent (Mishra et al., 2023). Social isolation shows a similarly wide range, from 3.6 to 86.4 per cent (Muralidharan et al., 2026), with rural community estimates around 63 per cent (Duraisamy et al., 2026) and old-age-home estimates around 84 per cent (Mishra et al., 2023).

Second, a consistent cluster of risk factors recurs across studies regardless of setting: advancing age, widowhood or unmarried status, poor physical health and chronic disease, poor mental health, low socio-economic status and financial dependency, nuclear-family or solitary living arrangements, and exposure to elder abuse (Mishra et al., 2023; Farid et al., 2014; Mehra et al., 2024; Duraisamy et al., 2026; Muralidharan et al., 2026; Vishwakarma et al., 2023).

Third, and most directly relevant to this review's focus, gender consistently shapes the pathway into isolation even when it does not always shape isolation's ultimate severity. Women's isolation is more often rooted in exclusion from family decision-making and relational life, whereas men's is more often rooted in loss of the economic-provider role (Farid et al., 2014). Women show a distinct and, in at least one study, an inverted relationship between loneliness and depression compared with men (Vijayshri & Farooqi, 2014). Widowhood and its associated financial and social consequences appear to affect women more severely than men, partly because of cultural constraints on widow remarriage and partly because of women's comparatively weaker independent asset base (Kumar & Bhargava, 2014). Financial dependency itself is significantly more common among women (Duraisamy et al., 2026). At the same time, once isolation and loneliness are present, their impact on broader psychological well-being does not appear to differ significantly by gender (Mishra et al., 2023), suggesting that the primary gender disparity lies in exposure and pathway rather than in the ultimate psychological consequence.

Fourth, elder abuse and caregiver mistreatment are strongly and consistently linked to both loneliness and, by extension, isolation, with caregiver abuse identified as one of the single strongest statistical predictors of loneliness in at least one rural sample (Mehra et al., 2024), and with women disproportionately represented among abuse victims nationally (Kumar & Bhargava, 2014).

Fifth, interventions proposed across this literature cluster around four broad categories: strengthening family and community engagement (visits, festivals, intergenerational contact); building formal community infrastructure such as recreation centres, day-care centres, and elder schools; improving access to health and social care, including geriatric clinics and home-based care; and strengthening legal and financial protections, including pensions and enforcement of maintenance legislation (Aroonsrimorakot et al., 2022; Mishra et al., 2023; Kumar & Bhargava, 2014; Vishwakarma et al., 2023).

Limitations of the Existing Research

Several methodological limitations recur across this body of work and constrain what can currently be concluded about the isolation of elderly women in India specifically.

The overwhelming reliance on cross-sectional designs is the most fundamental constraint. Nearly every primary study reviewed here — Mishra et al. (2023), Vijayshri and Farooqi (2014), Farid et al. (2014), Duraisamy et al. (2026), and Mehra et al. (2024) — collects all variables at a single time point, making it impossible to establish the direction of causality between, for example, loneliness and depression, or between caregiver abuse and isolation. Mehra et al. (2024) explicitly note that the relationship they

observe between loneliness and depression may be bidirectional rather than unidirectional, and call for longitudinal designs to resolve this.

Second, measurement heterogeneity across the literature is severe enough that Muralidharan et al. (2026) were unable to compute a pooled national prevalence estimate for either loneliness or social isolation, abandoning a planned meta-analysis after finding 99 per cent statistical heterogeneity (I^2) among eleven loneliness studies. Different studies use full or abbreviated UCLA scales, single-item yes/no loneliness questions, or the CES-D-10 loneliness item, each with different cut-off thresholds, making direct comparison across studies — including comparison of gendered subgroup findings — unreliable.

Third, several primary studies rely on small or non-representative samples. Mehra et al. (2024) surveyed only 125 elders at a single rural health clinic in Haryana; Farid et al. (2014) deliberately restricted their sample to the subset of 120 respondents (out of 385 screened) who self-identified as isolated, which by design excludes elders who may be isolated but do not perceive themselves as such; and Aroonsrimorakot et al. (2022) drew on a purposive qualitative sample of just 24 participants across two countries, limiting generalisability even within India.

Fourth, and most important for the specific purpose of this review, none of the nine sources takes elderly women as its sole or primary population of study. Gender-disaggregated findings — the core evidentiary basis for this review's conclusions about women's isolation — must be extracted as secondary or subgroup analyses from studies designed around the general elderly population (Farid et al., 2014; Vijayshri & Farooqi, 2014; Duraisamy et al., 2026) or from a broader synthesis of newspaper reports not originally designed as social-science data at all (Kumar & Bhargava, 2014). This means the evidence base for women-specific conclusions is thinner and less rigorously controlled than the evidence base for general elderly isolation.

Fifth, several studies explicitly exclude the most vulnerable subgroups — those with dementia, severe cognitive impairment, or terminal illness (Mishra et al., 2023; Vijayshri & Farooqi, 2014) — a group that skews female given women's greater longevity, meaning the true burden of isolation among the oldest and frailest women may be systematically underestimated.

Sixth, Kumar and Bhargava (2014) note a structural limitation affecting the entire Indian elder-abuse literature: the government does not systematically collect data on elder abuse or neglect, forcing researchers to rely on proxy sources such as newspaper content analysis, which carries obvious selection and reporting biases (only unusually severe or newsworthy cases are covered).

Finally, several studies acknowledge failing to control for variables likely to confound the isolation–well-being relationship, including physical comorbidity, detailed economic status, social support quality, coping style, and personality traits (Mishra et al., 2023; Mehra et al., 2024), and the geographic concentration of studies in a limited number of states (chiefly Punjab, Tamil Nadu, Haryana, Maharashtra, Chhattisgarh, and Karnataka) leaves large parts of the country, including much of India's northeast and several union territories, essentially unstudied (Muralidharan et al., 2026).

Unanswered Questions and Future Research Directions

This review surfaces several open questions that the existing literature has not yet resolved. Most fundamentally, no dedicated, adequately powered, longitudinal study exists that treats elderly Indian women as its primary population rather than as a subgroup within a mixed-gender sample; such a study would be needed to establish, with confidence, whether the gendered pathways into isolation identified here (relational exclusion for women, economic loss for men, per Farid et al., 2014) hold across regions, castes, and religious communities, or whether they are artefacts of the specific settings studied.

Second, the causal direction of the loneliness–depression–abuse triangle remains unresolved. Does caregiver abuse cause loneliness, does loneliness increase vulnerability to abuse by reducing oversight and social protection, or is the relationship bidirectional and mutually reinforcing? Mehra et al. (2024) raise this question explicitly but their cross-sectional design cannot answer it.

Third, none of the nine sources examines how intersecting disadvantages — illiteracy, caste, religion, disability, and rural residence — compound in shaping isolation risk specifically for women, even though Kumar and Bhargava (2014) gesture toward such compounding when discussing women's historic exclusion from education and asset ownership. A formal intersectional analysis, ideally using a large dataset such as LASI stratified simultaneously by gender and multiple markers of disadvantage, would substantially advance this field.

Fourth, the role of digital technology and digital literacy — proposed as a possible intervention by Aroonsrimorakot et al. (2022) — remains entirely untested empirically in this literature. Whether smartphone-based communication tools reduce or, alternatively, exacerbate isolation among elderly Indian women (who have historically had lower digital literacy than men) is an open and increasingly urgent question given rising smartphone penetration in rural India.

Fifth, the effectiveness of India's existing legal and welfare architecture — the Maintenance and Welfare of Parents and Senior Citizens Act 2007, the Integrated Programme for Senior Citizens, and national pension schemes — in actually reducing isolation among elderly women has not been empirically evaluated in any of the sources reviewed here; Mishra et al. (2023) and Kumar and Bhargava (2014) both note weak implementation but neither offers outcome data on whether, where implemented, these policies measurably reduce isolation or abuse.

Sixth, regions such as India's northeast remain almost entirely unstudied relative to the rest of the country, with Aroonsrimorakot et al.'s (2022) qualitative case study of Manipur standing as a rare exception; whether the family systems and gender norms distinctive to this region produce different isolation patterns than those documented in Punjab, Tamil Nadu, or Haryana is unknown.

Finally, none of the intervention frameworks proposed in this literature — including the four-part social facilitation, community, engagement, and health-care model developed by Aroonsrimorakot et al. (2022) — has been evaluated through a randomised

controlled trial or rigorous longitudinal follow-up in the Indian context, so their real-world effectiveness at reducing isolation among elderly women remains a matter of plausible inference rather than demonstrated evidence.

Conclusion

The isolation of elderly women in India sits at the intersection of demographic transition, family-structure change, gendered economic disadvantage, and gaps in health and social-protection systems. Across the nine sources reviewed, a consistent picture emerges: isolation and loneliness are prevalent and consequential for mental and physical health throughout India's elderly population, but the pathways into isolation, and several of its correlates — financial dependency, exclusion from family decision-making, vulnerability to abuse, and the loneliness–depression relationship itself — appear to operate differently, and in several respects more severely, for women than for men. At the same time, the evidence base remains fragmented: no study reviewed here was designed around elderly women as a primary population, measurement tools and cut-offs vary too widely to support pooled estimates, and almost all evidence is cross-sectional, leaving causal questions unresolved. A dedicated, longitudinal, gender-focused research agenda — ideally linked to rigorous evaluation of India's existing legal and welfare protections — represents the clearest path toward closing these gaps.

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