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LONELINESS AND PSYCHOSOCIAL VULNERABILITY AMONG OLDER ADULTS IN ROMANIA: STAKEHOLDER PERSPECTIVES ON CARE, SOCIAL ISOLATION, AND INSTITUTIONAL FRAGMENTATION

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Loneliness and Psychosocial Vulnerability among Older Adults in Romania: Stakeholder Perspectives on Care, Social Isolation, and Institutional Fragmentation

Eliza Monica MOTORGA[1]

Abstract

This study examines psychosocial vulnerability among older adults in Romania through a qualitative stakeholder analysis focusing on loneliness, emotional isolation, and fragmented care structures. The empirical material consists of 12 semi-structured interviews and 55 stakeholder questionnaires conducted between 2023 and 2024 with social workers, psychiatrists, caregivers, rehabilitation specialists, representatives of non-governmental organizations, and coordinators of residential and community-based services from Bucharest, Sibiu, Brașov, Timișoara, Craiova, and Galați. Data were analyzed using reflexive thematic analysis and inductive coding. The findings indicate that psychosocial vulnerability in later life is shaped not only by biological ageing but also by the interaction of migration-related family separation, weakened intergenerational relationships, declining community participation, institutional fragmentation, and limited access to psychosocial support. Across interviews and stakeholder questionnaires, loneliness emerged as the most persistent and under-recognized dimension of vulnerability, reflecting broader processes of social exclusion and relational disconnection. The article argues that psychosocial vulnerability should be understood as a socially produced and institutionally mediated condition rather than solely as an individual consequence of ageing. By highlighting the interconnected roles of emotional, relational, community, and institutional factors, the study contributes to current debates on ageing, social exclusion, care precarity, and welfare transformation in post-socialist societies. The findings also underscore the importance of integrated support systems and community-based interventions for promoting well-being in later life.

Keywords: psychosocial vulnerability; loneliness; older adults; stakeholder perspectives; Romania.

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Introduction

Population ageing is one of the most significant demographic transformations in contemporary Europe. In Romania, it unfolds alongside large-scale labor migration, regional inequalities, and uneven welfare provision. As a result, ageing is shaped not only by biological change but also by social isolation, weakened family ties, and unequal access to support. Since the early 1990s, labor migration has reshaped intergenerational relationships and patterns of family care. While many working-age adults have migrated abroad, older parents often remain in communities affected by depopulation and limited services. Although remittances alleviate material hardship, they rarely compensate for the loss of everyday interaction and emotional support.

Previous research has consistently associated loneliness and social isolation with poorer physical and mental health, cognitive decline, reduced quality of life, and increased mortality among older adults (Holt-Lunstad *et al*., 2015). More recent evidence further indicates that chronic loneliness represents a persistent public health concern requiring multidimensional interventions targeting both individual and community levels (Hajek *et al*., 2025). These concerns became even more visible during the COVID-19 pandemic, which exposed the vulnerability of many existing care and support systems (Fakoya *et al*., 2020). Despite growing international research on loneliness, social isolation, and psychosocial vulnerability in later life, limited attention has been given to how these issues are understood by professionals working with older adults in post-socialist contexts such as Romania.

Existing Romanian studies focus mainly on demographic ageing, migration, pensions, and healthcare, while the roles of emotional isolation, family separation, institutional fragmentation, and community support remain underexplored from care providers' perspectives. This article conceptualizes psychosocial vulnerability not as an inevitable outcome of biological ageing, but as a socially and institutionally produced condition shaped by emotional, relational, community, and structural processes. From this perspective, loneliness, emotional isolation, dependence anxiety, weakened intergenerational ties, and fragmented care are understood as interconnected dimensions of vulnerability rather than isolated problems.

Using qualitative data from professionals working with older adults in several Romanian cities, this study examines stakeholder understandings of psychosocial vulnerability, its causes, and support mechanisms. It contributes to research on ageing and social exclusion in post-socialist contexts by examining loneliness, intergenerational change, community participation, and institutional capacity. The study addresses the following research questions:

RQ1. How do stakeholders in Romania perceive psychosocial vulnerability among older adults?

RQ2. What causes and support mechanisms shape psychosocial vulnerability in later life?

Literature review

Population ageing is increasingly understood as a multidimensional social process shaped by inequalities, vulnerability, and access to support rather than solely by biological decline. Sociological research highlights that ageing experiences are influenced by transformations in welfare systems, labor markets, family structures, and community life. Consequently, later life should be analyzed within the broader social contexts that shape opportunities for participation, recognition, care, and well-being. Phillipson (2013) emphasizes that ageing in late modern societies is inseparable from structural transformations affecting welfare provision, social participation, and economic security. Similarly, Grenier (2012) conceptualizes vulnerability as a cumulative process developing across the life course through the interaction of individual circumstances and broader social conditions. Earlier sociological research also challenged the assumption that dependency in later life is primarily a biological consequence of ageing. Townsend (1981) demonstrated that dependence may be socially produced through institutional arrangements, welfare policies, and unequal access to resources. Within this broader perspective, loneliness has emerged as one of the central concepts in contemporary ageing research. Weiss (1973) distinguished between emotional loneliness, resulting from the absence of close emotional relationships, and social loneliness, reflecting insufficient integration into wider social networks. This distinction has informed widely used theoretical and empirical approaches to loneliness among older adults (De Jong Gierveld & Van Tilburg, 2006). Research consistently shows that loneliness extends beyond an emotional experience, functioning as a key determinant of health and well-being in later life. Perceived social isolation has been also associated with poorer cognitive functioning and reduced psychological resilience (Cacioppo & Hawkley, 2009), while more recent evidence links loneliness and social isolation to depression, psychological distress, and poorer mental health, particularly during the COVID-19 pandemic (Su *et al*., 2023).

Longitudinal studies further indicate that loneliness is associated with widowhood, declining mobility, shrinking social networks, and reduced community participation (Victor & Bowling, 2012). Contemporary research increasingly suggests that loneliness should not be interpreted solely as an emotional outcome of ageing but also as a mechanism through which broader forms of psychosocial vulnerability develop over time. Rather than functioning independently, emotional isolation interacts with declining social participation, weakened interpersonal relationships, reduced access to support, and institutional disadvantage, creating cumulative risks that extend beyond subjective well-being (Walsh *et al*., 2017). From this perspective, psychosocial vulnerability reflects the dynamic interplay between individual experiences and the relational and structural environments in which ageing occurs (Grenier *et al*., 2020). Recent research further emphasizes that loneliness is shaped through the interaction of individual, community, and societal factors, highlighting the importance of considering broader environmental contexts

alongside individual characteristics (Victor & Pikhartova, 2020). Building on these perspectives, loneliness can be understood as one interconnected dimension within a broader process of psychosocial vulnerability, particularly in societies undergoing demographic ageing, migration, and welfare transformation. Evidence syntheses further indicate that effective responses to loneliness require integrated strategies combining psychosocial support, community participation, and organizational interventions rather than relying on single approaches (Patil & Braun, 2024; Shekelle *et al*., 2024).

The sociology of care provides an important perspective for understanding these processes by emphasizing that support extends beyond material assistance and formal service provision. Hochschild's (1983) work on emotional labor highlighted the importance of emotional engagement within interpersonal relationships, while subsequent scholarship has stressed that effective care also depends upon emotional presence, recognition, and relational continuity. Lynch (2007) argues that care necessarily includes emotional commitment, affection, and interpersonal attachment that cannot be fully replaced through formal services or financial support alone. Recognition and social participation constitute additional dimensions of psychosocial vulnerability. Honneth (1995) argues that recognition represents a fundamental condition for dignity, self-esteem, and social inclusion. As societies increasingly value productivity, technological competence, and economic participation, older adults may experience declining social recognition and symbolic marginalization. Katz (2005) similarly suggests that ageing frequently involves tensions between continued participation and perceptions of declining social relevance. From this perspective, vulnerability is closely connected to broader processes of social exclusion, understood not only as material deprivation but also as restricted participation, diminished recognition, and unequal access to social resources (Silver, 1994). These processes are particularly salient in post-socialist societies such as Romania. Large-scale labor migration has significantly reshaped family relationships and traditional caregiving arrangements. Romanian studies show that migration-related family separation often weakens local support networks and reconfigures intergenerational solidarity (Sandu, 2010; Zimmer, Rada, and Stoica, 2014). Although remittances often improve material conditions, they cannot fully compensate for reduced emotional proximity and everyday interpersonal support. Lowenstein (2007) further demonstrates that contemporary intergenerational relationships are frequently characterized by a complex combination of solidarity, obligation, geographical distance, and emotional ambivalence.

Institutional contexts also shape vulnerability in later life. Stark and Bruszt (1998) describe post-socialist welfare transformation as a process characterized by uneven institutional development, fragmented governance, and inconsistent support structures. Similar challenges continue to affect the coordination of healthcare, social assistance, rehabilitation services, and community-based programs in Romania. Expanding this perspective, Fineman (2008) conceptualizes

vulnerability as a universal human condition whose consequences depend upon the institutional resources available to individuals rather than solely upon personal characteristics.

Finally, broader theories of social capital reinforce the importance of community relationships in shaping later-life vulnerability. Putnam (2000) argues that declining community participation weakens trust, reciprocity, and opportunities for mutual support. Similarly, research on social exclusion emphasizes that vulnerability emerges through the interaction of interpersonal relationships, community participation, access to resources, and institutional inclusion (Scharf & Keating, 2012; Walsh, Scharf, & Keating, 2017). Although these perspectives have advanced understanding of ageing, loneliness, and vulnerability, limited attention has been given to how professionals supporting older adults interpret these processes in post-socialist contexts. Romanian research has focused mainly on demographic ageing, migration, and healthcare, while stakeholder perspectives on psychosocial vulnerability remain underexplored. By examining how professionals understand its emotional, relational, community, and institutional dimensions, this study addresses this gap and contributes to a more comprehensive sociological account of ageing in contemporary Romania.

Methodology

This exploratory qualitative study examined stakeholder perceptions of psychosocial vulnerability among older adults in Romania. Qualitative inquiry was appropriate because the study sought to understand how professionals interpret loneliness, social isolation, family separation, dependency, and institutional support in practice (Creswell & Poth, 2018). Data were collected in 2023-2024 through semi-structured interviews and a complementary open-ended stakeholder questionnaire. The interviews provided in-depth support for patterns identified in the open-ended questionnaire.

Participants and sampling

Purposive sampling was used to recruit information-rich participants with direct professional experience of older adults (Patton, 2015). Twelve professionals from Bucharest, Sibiu, Brașov, Timișoara, Craiova, and Galați were interviewed, including social workers, physicians, rehabilitation specialists, care coordinators, program coordinators, and managers from public and private services. The sample comprised nine women and three men, aged 26–69, with 2–23 years of relevant experience. This professional diversity enabled comparison across health, social care, rehabilitation, residential, and community settings. Participant characteristics are summarized in Table 1.

Table 1. Characteristics of interview participants

Code	Gender	Age	Professional role	Institutional setting	City	Field experience
S1	F	26	Older-adult programme coordinator	Association established in collaboration with a foundation	Bucharest	4 years
S2	F	39	Senior physiotherapist	Private medical rehabilitation centre for older adults	Timișoara	6 years
S3	M	47	Psychiatrist working with older adults	Residential psychiatric care facility	Bucharest	9 years
S4	F	53	Association coordinator	Home care, home medical care and home physiotherapy services	Sibiu	8 years
S5	F	69	Director	Private residential home for older adults	Bucharest	23 years
S6	F	48	Director	Private association providing care for older adults	Brașov	5 years
S7	M	38	Care-services coordinator	Association providing home care and assistance	Bucharest	2 years
S8	M	53	Senior physician working with older adults	Private assistance centre for older adults	Craiova	11 years
S9	F	34	Social worker and director	Public residential care home	Timișoara	6 years
S10	F	42	Director	Public residential care home	Craiova	10 years
S11	F	34	Social worker	Humanitarian association with an older-adult focus	Sibiu	4 years
S12	F	59	Representative/ organizer of older-adult programmes and studies	Institution providing programmes/studies for older adults	Galați	3 years

Participant codes S1-S12 are used throughout the findings section. Interview quotations were translated from Romanian into English and lightly edited for grammatical clarity while preserving the original meaning; identifying details were omitted where necessary to maintain confidentiality.

Data collection and analysis

Semi-structured interviews provided thematic consistency while allowing participants to elaborate on professional experiences (Kvale & Brinkmann, 2009). Topics included loneliness, social participation, family support, migration, dependency, service access, and institutional coordination. Interviews were transcribed and analyzed thematically following Braun and Clarke's approach (2006, 2021), through familiarization, coding, theme development, review, and refinement. The analysis generated five interrelated themes reported below.

Research quality

The study prioritizes analytical depth over statistical representativeness. Credibility was supported by varied professional backgrounds, iterative comparison across interviews, and the stakeholder questionnaire, used to corroborate interview findings.

Ethical considerations

Participation was voluntary, informed consent was obtained, and data were anonymized. Participants could withdraw at any stage, and identifying organizational details were excluded from reporting.

Findings

The analysis identified five interrelated dimensions of psychosocial vulnerability among older adults in Romania: (1) loneliness and emotional isolation; (2) migration-related family separation; (3) perceived social irrelevance; (4) dependence anxiety; and (5) institutional fragmentation. Although presented separately, stakeholders described these dimensions as mutually reinforcing, illustrating how vulnerability emerges through the interaction of emotional, relational, and institutional processes rather than biological ageing alone. The themes are presented below with illustrative interview extracts to make the empirical basis of the analysis explicit. Quotations are used analytically to show how stakeholders articulated each dimension of vulnerability rather than as stand-alone illustrations.

Loneliness and emotional isolation

Loneliness was consistently identified as a core dimension of psychosocial vulnerability. Rather than a temporary condition, it was described as a gradual process shaped by widowhood, declining mobility, shrinking social networks, and reduced participation in social life. This pattern was particularly explicit in accounts from professionals providing home-based and residential services. One participant described loneliness as the most pervasive problem encountered in practice: "*First of all, what they all suffer from is loneliness... The children only pay. We have reached a point where money solves older people's problems, and that is not right. They are very eager to socialize and communicate, but loneliness wears them down*" (S4, association coordinator for home-care services). Another participant linked the intensification of loneliness to bereavement: "*When one member of the couple disappears, the situation becomes much more complicated, and loneliness is felt even more strongly*" (S3, psychiatrist working with older adults). These accounts show that stakeholders understood loneliness not simply as a low frequency of contact, but as the loss of emotionally meaningful relationships and everyday relational continuity. In this sense, emotional isolation was described as a process that can compound psychological distress and weaken older adults' engagement with daily life.

Migration-related family separation

Labor migration was frequently associated with emotional strain in later life. While financial support from relatives working abroad may alleviate material hardship, it does not compensate for the lack of regular interaction and emotional closeness. The interviews showed that this gap between material provision and relational presence was a recurrent practical concern. As one home-care coordinator explained, "*Most of their family members have gone abroad and come once every one, two, three, five years, depending; some never come, and from this point of view loneliness destabilizes them even more*" (S7, home-care and assistance services coordinator). A second participant described cases in which care organizations effectively assumed day-to-day responsibilities while family members abroad provided mainly financial support. Together, these accounts indicate that geographical distance reshapes intergenerational care by shifting routine support toward formal providers while leaving emotional and social needs only partially met. Older adults may therefore remain materially supported while experiencing persistent relational isolation.

Perceived social irrelevance and loss of recognition

A recurring concern was the diminishing sense of social value among older adults. This theme was expressed most clearly in participants' descriptions of how older people evaluate their place in contemporary social life. One program

coordinator observed that many older adults experience "*this feeling that they are useless, that they no longer keep up with what is happening around them, that what they know is no longer important, that what they think does not help anyone*" (S1, older-adult program coordinator). The same participant noted that such perceptions can occur even among older adults with adequate material resources when they lack opportunities to socialize and use their abilities and experience. The empirical pattern therefore concerns more than social contact alone: stakeholders described a loss of recognition and opportunities for meaningful contribution that can undermine self-confidence and encourage withdrawal from community life.

Dependence anxiety

Fear of dependency emerged as a significant factor influencing behavior in later life. It was closely tied to concerns about autonomy, dignity, and the possibility of becoming a burden on others. Participants described reluctance to acknowledge changing needs or to accept assistance. A director of a residential care center noted: "*There are many older people who find it very difficult to recognize that they have certain problems and need help*" (S5, director of a private residential home for older adults). A home-care coordinator also described a recurrent pattern in which families sought formal support only once older relatives could no longer manage without assistance: "*They turn to us when they really cannot manage anymore, when you are actually forced to care for them, although we also have cases where they contact us earlier*" (S4, association coordinator for home-care services). These accounts suggest that dependence is experienced not only as functional limitation but also through difficulties in acknowledging and responding to increasing care needs. In practice, delayed acceptance of assistance can leave older adults and their families seeking support only after autonomy has already substantially declined.

Institutional fragmentation

Institutional fragmentation constituted a fifth major theme. Participants described persistent difficulties in coordinating healthcare, rehabilitation, social assistance, and community-based services. The clearest accounts concerned the absence of standardized and trustworthy home-care pathways. One participant stated: "*Here in Romania, home care is too expensive; there is no adequate, trustworthy structure with qualified people... we are not talking about something centralized that is also of good quality and has certain standards. Here we can say*

that we are talking about systemic problems" (S1, older-adult program coordinator). A participant from Sibiu similarly emphasized the coordination problem: "*No matter how much the state or the private sector does, if they do not collaborate, if a system from A to Z is not created, nothing can be done*" (S4, association coordinator for home-care services). These accounts locate vulnerability partly in the organization of support itself: high costs, shortages of qualified personnel, uneven service availability, and weak coordination make it more difficult for older adults and families to identify and access appropriate care before needs become critical. Institutional fragmentation therefore interacts with family separation and dependence by shifting coordination responsibilities onto individuals, relatives, and individual service providers.

Protective factors and opportunities for intervention

Despite the emphasis on vulnerability, stakeholders identified factors that mitigate emotional isolation and support well-being. Community participation, rehabilitation programs, volunteer initiatives, intergenerational activities, and local support networks were highlighted as key resources. These protective effects were also described through direct observations of participants' own programs. A director involved in projects promoting social participation reported: "*We found after these activities that they greatly lack social interaction. When they had this, their condition was much better; their willingness to be active, to do things, and to have a good state of mind was very high*" (S6, director of a private older-adult care association). Another participant described day-center activities in which mobile older adults met for games, exercise, cognitive activities and intergenerational interaction with children (S4, association coordinator for home-care services). These accounts indicate that the protective value of such interventions lies not merely in occupying time, but in restoring routine interaction, opportunities for participation, and a sense of social connection. The data therefore point to community-based and intergenerational activities as practical mechanisms through which emotional isolation can be reduced and autonomy supported. Overall, the findings suggest that psychosocial vulnerability is not an inevitable outcome of biological ageing, but a socially and institutionally shaped process, responsive to interventions that strengthen social participation, coordinated support, and meaningful interpersonal connection.

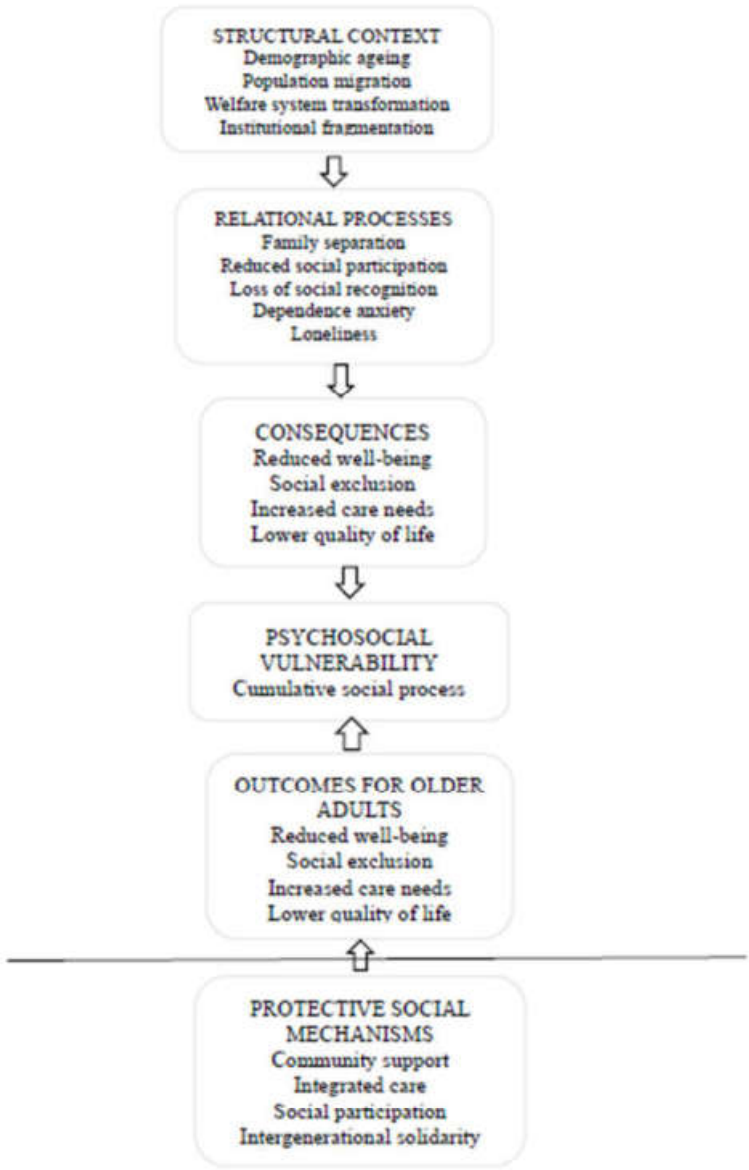

Figure 1. Conceptual framework of psychosocial vulnerability among older adults
Source: Authors' conceptualization based on the findings of the present study.

Discussion

The findings indicate that psychosocial vulnerability among older adults in Romania is relational and institutionally mediated, emerging through the interaction of loneliness, family separation, social recognition, dependence, community participation, and fragmented support.

The centrality of loneliness reinforces a growing body of gerontological research identifying social isolation as a major challenge in later life. Participants described loneliness not as a temporary condition, but as a cumulative process associated with bereavement, shrinking social networks, declining mobility, and reduced opportunities for meaningful participation. These findings support Weiss's (1973) distinction between emotional and social loneliness and align with research emphasizing its multidimensional nature (De Jong Gierveld & Van Tilburg, 2006). They also resonate with broader conceptualizations of social exclusion that highlight the interaction between individual experiences, participation, and structural inequalities (Walsh, Scharf, & Keating, 2017). Importantly, loneliness emerged not only as a psychological experience but as a socially embedded condition shaped by changing family structures, declining community participation, and weakening interpersonal ties. In this respect, the findings echo Elias's (1985) observations on the narrowing of social worlds in later life, while extending them through contemporary stakeholder perspectives from Romania.

Migration-related family separation illustrates this relational dimension. Participants distinguished material from emotional support, noting that remittances cannot replace everyday interaction. This finding supports Lynch's (2007) argument that care depends on emotional commitment and relational continuity and complements Lowenstein's (2007) account of intergenerational solidarity under geographical distance.

Perceived social irrelevance further shows how vulnerability is shaped by recognition and participation. Participants' accounts of declining visibility and social value are consistent with Honneth's (1995) theory of recognition and Katz's (2005) analysis of tensions between ageing, participation, and perceived relevance.

Institutional fragmentation was likewise central. Difficult coordination among healthcare, social assistance, rehabilitation, and community services contributed to uncertainty and uneven support, consistent with analyses of fragmented post-socialist welfare development (Stark & Bruszt, 1998).

In line with Fineman's (2008) conceptualization, vulnerability emerged as a condition produced through the interaction between individuals and institutional resources. Rather than resulting from isolated circumstances, it developed cumulatively through personal loss, family change, reduced participation, and limited access to coordinated support. This perspective challenges interpretations of vulnerability as an inherent characteristic of older age and instead positions it as socially and institutionally mediated. At the same time, stakeholder accounts

point to the protective role of community participation. Opportunities for social interaction, volunteering, rehabilitation programs, and intergenerational activities were consistently described as mitigating emotional isolation. This aligns with evidence that sustained social participation is among the most effective ways to reduce loneliness (Hoang *et al*., 2022), as well as with Putnam's (2000) concept of social capital and research emphasizing the multidimensional nature of social exclusion in later life (Scharf & Keating, 2012).

The five themes can therefore be synthesized into four analytical dimensions: emotional relationships, family and intergenerational ties, community participation, and institutional capacity. Their interaction explains how psychosocial vulnerability develops cumulatively and varies according to available relational and institutional resources.

Emotional isolation, migration-related separation, dependence anxiety, weakened recognition, and institutional fragmentation should consequently be understood as mutually reinforcing rather than independent disadvantages. This relational interpretation connects experiences often examined separately within research on loneliness, social exclusion, and care.

The study's theoretical contribution is to conceptualize psychosocial vulnerability as a relational and institutionally mediated process. Integrating emotional relationships, family dynamics, community participation, and institutional capacity within one framework also repositions loneliness from a discrete outcome to a constitutive element of cumulative vulnerability.

The policy implication is that responses must extend beyond healthcare. Better coordination between health and social care, psychosocial support, community participation, and opportunities to sustain intergenerational relationships are all relevant. This is consistent with evidence favoring coordinated, cross-sector responses to loneliness rather than isolated interventions (Noone & Yang, 2022).

Although grounded in Romania, these mechanisms may inform comparative research on post-socialist societies experiencing demographic ageing, migration, and welfare transformation.

Conclusion

This study analyzed psychosocial vulnerability among older adults in Romania through the perspectives of professionals in healthcare, social assistance, rehabilitation, and community services. Vulnerability emerged as an interaction of emotional, relational, community, and institutional processes rather than a consequence of biological ageing alone.

Loneliness was the most pervasive dimension but interacted with migration-related family separation, dependence anxiety, reduced social recognition, limited participation, and fragmented support. The study therefore conceptualizes

psychosocial vulnerability as a cumulative relational process structured by emotional relationships, intergenerational dynamics, community participation, and institutional capacity.

Policy responses should combine service coordination and psychosocial support with initiatives that strengthen social participation and intergenerational relationships, rather than relying on healthcare provision alone (World Health Organization, 2021).

Although focused on Romania, the mechanisms identified may be relevant to comparable post-socialist contexts. Future research should incorporate older adults' own perspectives and comparative designs.

Limitations

The exploratory design is not statistically generalizable and relies on stakeholder perspectives that may differ from older adults' lived experiences. Recruitment from selected urban and institutional settings limits regional coverage, while data collected in 2023–2024 cannot capture change over time. Nevertheless, the research shows how emotional, relational, community, and institutional factors interact in psychosocial vulnerability and supports integrated approaches to later-life well-being.

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