Digital technology and wellbeing in older adults: social connection, digital exclusion and clinical implications

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Abstract

Digital technologies are increasingly embedded within the social, healthcare and civic environments of older adults. Smartphones, online communication platforms, video-calling applications, digital health services and internet-based information systems may support social connection, independence and access to essential services. However, unequal access to technology, limited digital confidence, cognitive and sensory difficulties and exposure to online misinformation and fraud may also create new forms of exclusion and vulnerability. This article examines the relationship between digital technology, social isolation and wellbeing in later life, considering the interaction between individual characteristics, social relationships and wider structural inequalities. Evidence suggests that digital communication may support wellbeing when it facilitates meaningful social relationships, although technology alone cannot resolve loneliness or social isolation. Digital exclusion may also function as a social determinant of health, particularly as healthcare and public services increasingly move online. Cognitive changes

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Key points

- Digital technology may support social connection and wellbeing in later life when it facilitates meaningful relationships and participation.
- Digital engagement should not be assumed to reduce loneliness; the quality, purpose and social context of technology use are clinically important.
- Digital exclusion may contribute to health inequalities by limiting access to healthcare, information, social networks and essential services.
- Cognitive change may make some digital environments more difficult to navigate, while appropriately designed technology may support memory, independence and communication.
- Older adults may experience online misinformation, scams and financial exploitation, with psychological consequences that can include anxiety, shame and reduced confidence.
- Clinical assessment should consider digital access, social connection, cognitive functioning, online safety, functional impact and available support.
- Digital inclusion is a shared responsibility and should complement, rather than replace, face-to-face care, community support and non-digital access routes.

may create difficulties navigating complex digital environments; though, appropriately designed technologies may support memory, independence and communication. From a clinical perspective,

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assessment should consider digital access, confidence, social connection, cognitive functioning and online safety alongside conventional psychosocial assessment. An integrated approach involving healthcare professionals, social care, community organisations and digital inclusion services may help older adults participate safely and meaningfully in an increasingly digital society.

Keywords Cognitive ageing; digital exclusion; digital technology; integrated care; loneliness; older adults; scams; social isolation; wellbeing

Introduction

Population ageing represents one of the most significant demographic transitions of the twenty-first century.[1,2] As life expectancy increases, a growing proportion of the population is entering older adulthood, often alongside changes in health, mobility, social networks and patterns of participation. At the same time, digital technologies have become increasingly embedded within everyday life. Communication with family members, access to healthcare, financial management, information seeking and participation in community life may now involve smartphones, online platforms and digital services.

These developments create important clinical and sociological questions. Digital technology may provide opportunities for older adults to maintain relationships, access information and preserve independence. However, the ability to benefit from these opportunities is uneven. Access to suitable devices, reliable connectivity, digital skills, confidence, physical and cognitive functioning and social support may all influence whether an individual is able to participate effectively in an increasingly digital society. Older adults should therefore not be understood as a uniform group in relation to technology. Later life encompasses considerable variation in age, health, education, socioeconomic circumstances, disability, cognitive functioning, previous occupational experience and exposure to digital technologies across the life course. A simple distinction between technologically capable younger people and technologically incapable older people is consequently inadequate. Digital engagement is shaped by the interaction between age, life-course experience, resources, health and the environments in which technology is used.

The clinical relevance of these issues is increasing. Digital access may influence the ability to communicate with family, access healthcare, manage finances and participate in social life. Conversely, digital exclusion may contribute to isolation, reduced autonomy and difficulty accessing essential services. Social isolation and loneliness are themselves important determinants of health and wellbeing in later life, and the World Health Organisation identifies high-quality social connection as an important component of healthy ageing.[1,2] Understanding the relationship between technology and wellbeing therefore requires attention not only to individual behaviour but also to the social and institutional environments in which digital participation occurs.

Digital connection, social isolation and wellbeing

Social isolation and loneliness are important determinants of health in later life. Although related, they represent different experiences. Social isolation generally refers to limited social contact or a restricted social network, whereas loneliness reflects a subjective perception that one's social relationships are insufficient in quantity or quality. An older adult may therefore have regular contact with other people while continuing to experience significant loneliness.[3]

Later life may involve transitions that alter established social networks, including retirement, bereavement, reduced mobility, chronic illness and relocation. These changes may reduce opportunities for face-to-face contact and increase the risk of social disconnection. Digital communication can provide an additional means of maintaining relationships when geographical distance, physical disability or reduced mobility make in-person contact more difficult.

Research has suggested that social technology use may be associated with improved wellbeing among older adults. Chopik (2016), for example, found that social technology use was associated with lower loneliness and greater life satisfaction, with perceived social support contributing to this relationship.[4] The study examined technology-based social behaviours including email, social networking, online calls, messaging and smartphone use. These findings suggest that the potential benefit of digital technology may arise primarily from the relationships and social support that technology facilitates rather than from technology use in isolation. Technology-based interventions may also contribute to reductions in loneliness. In a systematic review and meta-analysis of 70 studies involving 8,259 participants, Hoang et al. (2022) found that interventions including technology-based approaches, psychotherapy, exercise and multicomponent interventions were associated with reductions in loneliness.[5] However, the authors identified considerable heterogeneity between interventions and populations. Technology should therefore be regarded as one possible component of a broader strategy to support social connection rather than as a universal treatment for loneliness.

The quality and purpose of digital engagement are therefore important. An online interaction may strengthen an existing relationship, allow an older person to participate in family life or provide access to a meaningful community. Alternatively, digital engagement may be superficial, confusing or experienced as a poor substitute for desired face to face contact. The same technology may consequently have very different effects depending on the individual's circumstances and the

social relationships that it facilitates. The relationship between digital engagement and wellbeing may also be bidirectional. Individuals who are healthier, more socially connected and psychologically well may be more likely to adopt and use digital technologies confidently. At the same time, digital communication may help maintain the relationships that contribute to wellbeing. Conversely, depression, bereavement, cognitive impairment or physical disability may make digital engagement more difficult, potentially reinforcing existing social exclusion.

The COVID-19 pandemic demonstrated both the potential and limitations of digital connectivity. During periods of social distancing and restricted mobility, many older adults used digital technologies to maintain contact with family members, participate in community activities and access healthcare. However, individuals without appropriate devices, reliable internet access, digital confidence or practical support faced additional barriers to social and healthcare participation.[6] The pandemic therefore highlighted the importance of digital access while also demonstrating that digital inclusion is unevenly distributed.

Digital communication should consequently be understood as one possible component of social connection rather than a replacement for human relationships. For some older adults, technology may provide an important route to participation. For others, telephone contact, face to face interaction or community- based activities may be more meaningful.[7]

Clinical assessment should therefore focus on the individual's experience and preferences rather than assuming that increased digital engagement is inherently beneficial.

Digital exclusion as a social determinant of health

Digital exclusion is increasingly relevant to health and social participation. Access to a device or internet connection does not necessarily constitute meaningful digital inclusion. An older adult may own a smartphone but lack confidence using video- calling applications, have internet access but be unable to navigate online healthcare systems, or possess a device that is unsuitable because of visual, auditory, motor or cognitive difficulties. Digital inclusion is increasingly understood as extending beyond physical access to include digital skills, confidence, affordability, accessibility and the ability to use technology safely and meaningfully.[8]

Digital exclusion may arise through multiple interacting factors, including financial constraints, limited digital literacy, disability, sensory impairment, geographical location and lack of social support. These factors frequently intersect with wider inequalities. Older adults living on limited incomes may be unable to afford appropriate devices or connectivity, while those living in rural areas may experience reduced access to reliable infrastructure. Individuals with limited social networks may also have fewer opportunities to receive informal assistance with technology. Recent evidence suggests that digital exclusion among older adults reflects interacting individual, social and structural factors rather than age alone.[9]

The consequences may extend beyond inconvenience. As healthcare, financial services and public services increasingly move online, digital exclusion may create additional barriers to accessing essential resources. Individuals who cannot navigate online appointment systems, health information platforms or digital communication may become increasingly dependent on family members, carers or professionals. Digital exclusion may therefore contribute to reduced autonomy and participation. Studies examining digital inequalities in older adults have highlighted that exclusion from digital systems may coexist with social exclusion and contribute to broader health inequalities.[10]

Digital exclusion may consequently function as a social determinant of health. It can influence access to information, healthcare, social relationships and civic participation. From a sociological perspective, the issue is not simply whether an individual has developed sufficient technological skills. It is also necessary to consider whether digital systems have been designed in ways that allow diverse populations to participate. The concept of digital inequality therefore extends beyond access to include skills, confidence, affordability, accessibility, support and the ability to use technology safely and meaningfully.[8,9]

This has important implications for integrated care. Digital transformation may improve access and efficiency for some patients while creating new barriers for others. Healthcare systems should therefore avoid assuming that all older adults can engage digitally without support. Maintaining accessible non-digital routes to care remains important, particularly for individuals experiencing cognitive impairment, sensory disability, poverty or limited connectivity. Digital health interventions may unintentionally widen existing inequalities if implementation does not consider differences in digital access, literacy, disability and social support.[11]

Digital inclusion should consequently be understood as a shared responsibility. Individuals may benefit from developing digital confidence, but families, communities, healthcare providers, technology designers and policymakers also influence whether digital environments are accessible and safe. A focus solely on individual digital skills risks locating responsibility for exclusion within the person rather than within the broader systems that increasingly require digital participation.

Cognitive ageing and technology engagement

Cognitive ageing may also influence how older adults interact with digital technologies. Normal ageing may involve changes in processing speed, attention, working memory and executive functioning, while some individuals develop mild cognitive impairment or neurodegenerative conditions. These changes may make complex digital environments more difficult to navigate. Age-related cognitive changes do not necessarily prevent technology use but may increase the demands placed on memory, attention and problem-solving during digital interaction.[12]

Digital systems increasingly require users to remember passwords, interpret information, identify trustworthy sources and complete multiple steps.[12] Such demands may create difficulties for individuals experiencing cognitive changes, particularly where interfaces rely on complex navigation, inconsistent layouts or high levels of information processing.[12] For an individual experiencing cognitive difficulties, these demands may contribute to frustration, anxiety or dependence on others. However, difficulty using a particular digital system should not automatically be interpreted as evidence of significant cognitive impairment. Poorly designed or inaccessible interfaces may create difficulties even for individuals without clinically significant cognitive decline. Technology may also provide compensatory support. Calendars, medication reminders, alarms, voice assistants and simplified communication systems may reduce the cognitive demands associated with remembering appointments, medication schedules and important events. Digital tools may therefore support independence when they are appropriately designed and acceptable to the individual. Assistive technologies have been explored in dementia care as a means of supporting memory, safety and daily functioning, although effectiveness depends strongly on individual needs, usability and acceptance.[13]

mining, AI training, and similar technologies.

Research has also examined whether learning to use technology may itself provide cognitive stimulation. In a controlled study of older adults who were trained to use tablet computers, Chan et al. (2016) reported improvements in episodic memory and processing speed compared with control groups.[14] Such findings are of interest because they suggest that learning a new technology may involve cognitively demanding activity. However, the findings should not be interpreted as evidence that technology training prevents dementia or reverses neurodegenerative disease.

This relationship is particularly important in dementia care. Reminder systems, communication tools and other assistive technologies may help individuals remain independent for longer. However, the use of technology should remain person- centred. A device that improves safety for one person may feel intrusive or distressing to another. The clinical objective should therefore be to balance safety with autonomy, privacy and quality of life. Technology acceptance in dementia care is influenced not only by cognitive ability but also by personal identity, preferences, previous experience, caregiver involvement and perceptions of dignity.[13,15] Cognitive change may also increase vulnerability to online scams and misinformation in some individuals. Difficulties with memory, attention or executive functioning may make it harder to evaluate complex information or identify inconsistencies. However, age or cognitive impairment should not be treated as sufficient explanations for digital vulnerability. Online scams are increasingly sophisticated and may deceive people across the lifespan. Digital vulnerability is therefore better understood as arising from the interaction between individual cognitive abilities, emotional states, social circumstances and the characteristics of online environments.[16,17]

The clinical question is therefore not whether an older adult can use technology in general, but whether particular digital environments are accessible, meaningful and safe for that individual. Assessment should distinguish between personal preference, lack of confidence, inaccessible design, functional cognitive impairment and clinically significant decline.

Online misinformation, scams and vulnerability

Digital environments provide access to health information, financial services and social communication but may also expose older adults to misinformation and fraud. Health misinformation may contribute to anxiety, inappropriate self-treatment or reduced trust in evidence-based care. Fraudulent communication may involve phishing, impersonation, fake technical support, fraudulent investments or romance scams. These risks should not be understood simply as evidence of individual gullibility. Online scams are often deliberately designed to exploit trust, urgency, fear and emotional vulnerability. Risk may be influenced by digital literacy, social isolation, financial circumstances, cognitive functioning and the wider design of online environments. Older adults may be particularly affected where online risks interact with factors such as bereavement, loneliness, reduced confidence, cognitive change or limited access to trusted support.[16]

Research has demonstrated that age may be associated with differences in exposure to and sharing of certain forms of online misinformation, although age alone is not a sufficient explanation. In a large study of Facebook activity during the 2016 United States presidential election, Guess, Nagler and Tucker (2019) found that older users shared more articles from fake-news domains than younger users.[18] The findings should not be interpreted as demonstrating that older adults are inherently gullible. Rather, they highlight the importance of considering the interaction between age, digital experience, media use and information environments. Digital misinformation exposure is influenced by broader factors including political context, platform design, patterns of online engagement and individual differences in digital literacy.[18]

The psychological consequences of fraud may be substantial. Financial loss may threaten independence and security, while the experience of being deceived may result in shame, anxiety, anger and reduced confidence. Some individuals may avoid disclosure because they fear that family members or professionals will view them as incapable of managing their own affairs. This may delay support and increase the risk of repeated victimisation. Financial exploitation in later life has been associated with adverse psychological outcomes, including depression, reduced wellbeing and increased vulnerability to further harm.[16]

Clinicians should therefore consider online vulnerability when older adults present with new anxiety, sleep disturbance, low mood or unexplained financial concerns. Sensitive, non- judgemental enquiry may create an opportunity for disclosure.

Questions might include whether the individual has recently received unexpected requests for money or personal information, whether anyone online has pressured them to act urgently, or whether they have experienced uncertainty about whether a communication was genuine. Assessment should aim to identify risk while preserving autonomy and avoiding assumptions that older adults are unable to make decisions independently.[19]

The aim should be to support safer participation rather than unnecessarily restrict access to technology. Excessive restriction may increase isolation, particularly where online communication is an important source of social connection. Prevention should therefore combine practical education with appropriate safeguarding, social support and institutional protections. Interventions that focus only on individual awareness may be insufficient because online harms are shaped by the design of digital platforms, financial systems and communication environments.[20]

Digital safety also requires responses beyond individual education. Accessible reporting systems, effective fraud prevention and community support are important components of prevention. The responsibility for preventing online harm should not rest solely with older adults, particularly when digital systems are increasingly required for everyday participation. A public health approach to digital safety therefore requires collaboration between healthcare providers, financial organisations, technology companies, policymakers and community services.

Clinical implications

The increasing integration of technology into everyday life suggests that digital engagement may become an increasingly relevant component of holistic clinical assessment. The purpose is not to determine whether an older person is sufficiently technologically capable, but to understand whether digital environments are supporting or restricting wellbeing, independence and participation.

Clinicians may consider several interconnected domains during assessment. These include whether the individual has access to a suitable device and reliable connectivity; whether they feel confident using digital technologies relevant to their everyday needs; whether digital communication supports meaningful relationships; and whether visual, auditory, motor or cognitive difficulties create barriers to use. Assessment should also consider experiences of misinformation, scams or financial exploitation, the availability of family or community support,

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and the functional impact of digital exclusion on healthcare access, social participation and independence.

A brief clinical assessment framework is presented in Table 1.

These domains should be explored flexibly according to the individual's circumstances rather than applied as a fixed assessment battery. Digital exclusion may contribute to loneliness, while cognitive difficulties may affect online safety. Conversely, appropriately selected technologies may support communication, memory and independence. Assessment should therefore be integrated with broader psychosocial and functional evaluation.

Standardised measures may provide additional structure where clinically indicated, but digital engagement should not be assessed separately from established evaluation of loneliness, social networks, mood, cognition and quality of life. Such measures may help clarify whether difficulties with digital participation reflect broader social disconnection, psychological distress or cognitive change. However, clinical interpretation should extend beyond individual scores and consider the person's social circumstances, functional abilities, support networks, accessibility needs and the design of the digital environment. This approach is consistent with models of healthy ageing that emphasise the interaction between intrinsic capacity, functional ability and environmental factors rather than focusing solely on impairment.[21]

Clinical enquiry framework for digital wellbeing in older adults

Clinical domain	Key clinical question
Digital access	Can the person access the technology needed for everyday life?
Social connection	Does digital communication support meaningful relationships?
Cognitive functioning	Are memory or executive difficulties affecting technology use?
Digital safety	Is the person experiencing scams, misinformation or exploitation?
Functional impact	Is technology supporting or limiting independence?
Support and equity	What social, community or professional support is available?

Table 1

Digital wellbeing should therefore be considered as part of person-centred clinical evaluation rather than as a separate measure of technological ability.

Integrated care is particularly important because no single professional or service can address all aspects of digital inclusion. Medical professionals, including primary care clinicians, geriatricians and psychiatrists, may identify digital exclusion, distress, changes in functioning, cognitive concerns or difficulties accessing digitally mediated healthcare. Occupational therapists may support adaptation, accessibility and assistive technology, while social workers and social prescribing services may connect individuals with community resources and practical support. Pharmacists, where appropriate, may also identify barriers relating to digital health services, medication management and access to online information. Libraries, voluntary organisations and community groups can provide accessible opportunities for digital learning and confidence-building. A coordinated approach involving health, social care and community services is required to ensure that digital transformation enhances participation, autonomy and wellbeing rather than creating additional barriers.

Conclusion

Digital technology is increasingly embedded within the social and healthcare environments of older adults. It may support social connection, independence and access to services, but its benefits are not universal or automatic. Digital exclusion, cognitive difficulties, online misinformation and fraud may create new forms of vulnerability, particularly where digital systems become essential to everyday participation. The impact of technology on wellbeing is therefore shaped by the interaction between the individual and their social, clinical and technological environment. Digital inclusion should be understood not simply as access to a device but as the ability to participate meaningfully, safely and autonomously.

For clinicians working across integrated care, digital engagement represents an increasingly relevant component of holistic assessment. Understanding how older adults access, use and experience technology may provide important insight into social connection, wellbeing, independence and health inequality. A balanced approach is required: technology should be supported where it enhances the individual's goals and relationships, while non-digital alternatives and wider community support remain available.

Digital inclusion may ultimately represent an important component of healthy ageing, but its success depends on ensuring that technological transformation expands participation rather than reproducing existing social and health inequalities.

Author contributions

NK conceived the idea and wrote the first draft. All authors contributed to the editing and revision of the manuscript. All authors approved the final version of the manuscript. ◆

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