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Social and emotional skills for healthy ageing: a critical review of current challenges and future perspectives

Abstract

Healthy ageing depends not only on disease prevention and the preservation of physical functioning, but also on the capacity to cope adaptively with changes, losses, transitions, and relational and emotional challenges. Building on prior research demonstrating the relevance of emotional intelligence to geriatric care, this article broadens that perspective by analyzing the role of socio-emotional skills in promoting healthy ageing. A critical and interpretative review is developed, critically integrating conceptual, theoretical, and empirical contributions on emotional regulation, resilience, adjustment to retirement, active ageing, social participation, depression prevention, and psychological well-being. The analysis seeks to overcome the fragmentation of these domains by examining their interrelationships and the conditions under which socio-emotional skills may favor adaptive coping, resilience, social participation, mental health, and a meaningful life. The implications for clinical and gerontological practice, multidisciplinary intervention, and the development of preventive and well-being promotion strategies are also discussed. The review highlights the need for approaches that recognize the heterogeneity of ageing and simultaneously consider individual, relational, social, and contextual factors. Finally, priorities for research and intervention are identified, including longitudinal, cross-cultural, and intervention-effectiveness studies to strengthen socio-emotional skills across the life course.

Keywords: socio-emotional skills; healthy ageing; emotional regulation; resilience; active ageingolder adults; social participation; psychological well-being

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Abbreviations: WHO, world health organization; AI, artificial intelligence; EI, emotional intelligence

Introduction

Population ageing and increased longevity constitute some of the most significant demographic transformations of contemporary societies, challenging traditional conceptions centred predominantly on disease, disability, and dependency. In parallel, a multidimensional perspective on ageing has become consolidated, valuing the maintenance of capacities, adaptation to age-related changes, and social participation. Ageing has thus ceased to be understood exclusively as a process of decline. It has come to be analyzed as a process of development and adaptation, in which individuals mobilize selection, optimization, and compensation strategies to manage gains and losses across the life course.[1,2]

This conceptual change is reflected in the concept of healthy ageing developed by the World Health Organization (WHO, 2020, 2021).[3,4] Rather than defining it by the absence of disease, the organisation emphasises the development and maintenance of functional ability that enables well-being in older age. Functional ability results from the interaction between a person's intrinsic capacities and the physical, social, and institutional environments in which they live, including the capacity to meet basic needs, learn and make decisions, maintain mobility, establish relationships, and contribute to society. This perspective reinforces the need to understand ageing beyond a predominantly biomedical approach, integrating physical, psychological, relational, and social dimensions.

Physical health remains fundamental in view of the prevalence of chronic diseases, multimorbidity, pain, and functional limitations; however, the quality of ageing also depends on the capacity to cope adaptively with these conditions, preserve possible autonomy, maintain meaningful relationships, and participate in activities that provide purpose and meaning.[4] Changes associated with ageing may involve the loss of significant people, changes in health, retirement, the reorganization of social roles, and changes in economic and relational conditions. However, these experiences do not necessarily lead to negative psychological consequences, since ageing involves adaptation processes in which individual resources, psychological strategies, and social and contextual conditions interact.[1,5] Socioemotional selectivity theory adds that the perception of remaining lifetime influences social and motivational priorities and may favor, when the future is perceived as more limited, goals related to emotional regulation and the maintenance of meaningful relationships.[6]

In this context, the socio-emotional dimension of ageing becomes particularly relevant. This perspective builds on previous research on the role of emotional intelligence (EI) in geriatric care.[7] EI refers to abilities involving the perception, understanding, use, and regulation of emotional information, whereas socio-emotional skills encompass a broader set of emotional, interpersonal, social, and adaptive capacities. These include emotional regulation, the establishment and maintenance of meaningful relationships, communication of needs, mobilisation of social support, coping with change, and participation in socially meaningful activities. This distinction is important because healthy ageing depends not only on emotional self-management but also on the capacity to use emotional and interpersonal resources to adapt to changing circumstances and maintain meaningful engagement with social and environmental contexts. Accordingly, the present article adopts socio-emotional skills as the broader conceptual framework, with EI as one relevant but not exhaustive dimension.[1,5]

Research suggests that emotional processes do not remain static throughout the life course. Older adults may use different emotion regulation strategies, although these should be understood in relation to individual characteristics, health conditions, and social contexts.[5,8] Likewise, resilience is understood as a dynamic process of adaptation in the face of adversity, involving individual resources, social relationships, and contextual conditions.[9,10] From this perspective, socio-emotional skills may constitute relevant resources for coping with losses, preserving meaningful relationships, mobilizing social support, and fostering adaptive responses to change, without attributing exclusive responsibility for healthy ageing outcomes to the individual.

Despite the growing interest in these dimensions, the literature remains relatively fragmented, with emotion regulation, resilience, retirement, active ageing, social relationships, loneliness, depression and psychological well-being frequently analyzed as distinct domains. This fragmentation may hinder an integrated understanding of their interrelationships and of the conditions under which different psychological and social resources jointly contribute to adaptation to ageing. A biopsychosocial perspective is therefore necessary, given the interactions among individual characteristics, health, social relationships, and environmental conditions in promoting healthy ageing.[2,4]

It is within this conceptual space that the present article is situated. The aim is to critically analyse the role of socio-emotional skills in promoting healthy ageing, integrating conceptual, theoretical, and empirical contributions on emotion regulation, resilience, adaptation to retirement, active ageing, social participation, prevention of depression, and psychological well-being. Through a critical and interpretative review, the article identifies convergences, divergences, limitations, and gaps in the literature and develops an integrative interpretation oriented towards gerontological practice and future intervention and research. The discussion progresses from the conceptualisation and development of socio-emotional skills to their relationships with adaptation, mental health, well-being, clinical practice, and future research priorities.

Methodological approach: critical and interpretative review

Nature and purpose of the review

The present study adopts a critical and interpretative review approach, integrating and critically interpreting relevant conceptual, theoretical, and empirical contributions to understanding socio-emotional skills in the context of healthy ageing. This approach is appropriate for examining a multidimensional topic that intersects psychological, social, relational, gerontological, and health-related perspectives. Rather than seeking to exhaustively identify all available publications or quantitatively estimate the combined effect of findings, the review aims to construct an integrated interpretation of the available knowledge, identifying conceptual relationships, convergences, divergences, limitations, and gaps in the literature.[11–15]

The review combines foundational contributions that established key concepts and theoretical models with empirical and conceptual research addressing their subsequent development and application to ageing. This combination enables examination of how socio-emotional skills relate to emotional regulation, resilience, retirement adaptation, active ageing, social participation, depression, and psychological well-being, while also considering the individual, relational, and contextual conditions that may influence these relationships.

Literature identification and selection criteria

The literature was identified purposively in accordance with the objectives and conceptual scope of the review. Selection focused on publications that made a substantive contribution to understanding socio-emotional functioning and healthy ageing, including conceptual, theoretical, and empirical studies addressing emotional regulation, EI, resilience, coping, self-efficacy, social relationships and support, retirement adaptation, active ageing, social participation, depression, psychological well-being, and related dimensions of adaptation in later life.

Publications were considered eligible when they: (a) addressed older adults or processes directly relevant to ageing and later-life adaptation; (b) examined at least one psychological, socio-emotional, relational, or contextual dimension relevant to healthy ageing; (c) provided conceptual, theoretical, empirical, or review-based evidence capable of informing the interpretation of the topic; and (d) contributed directly to one or more of the conceptual domains established for the present review. Foundational publications were retained when necessary to define or explain established theoretical constructs or models, whereas more recent literature was used to examine their contemporary development, empirical applications, and relevance to current ageing-related challenges.

Publications were excluded when they were unrelated to ageing or later-life adaptation, focused exclusively on biomedical or clinical outcomes without a relevant psychological, socio-emotional, relational, or contextual dimension, or did not provide substantive information for the conceptual domains addressed in the review. Selection was therefore based on conceptual and thematic relevance rather than on a predetermined quantitative target or statistical aggregation of findings. The objective was not to treat all identified publications as equivalent units of evidence, but to select contributions capable of informing critical comparison and theoretical integration across the different domains examined.

Analysis strategy and interpretative synthesis

The selected literature was organised around the main conceptual domains defined by the review's objective: socio-emotional skills, emotional regulation, resilience, retirement adaptation, active ageing, social participation, depression, and psychological well-being. The analysis focused on identifying convergences, divergences, theoretical assumptions, methodological limitations, and gaps across these domains.[11,13,15]

The synthesis was developed through critical comparison and interpretative articulation of the selected contributions, with particular attention to the mechanisms through which socio-emotional skills may relate to adaptation, coping, emotional regulation, resilience, social participation, mental health, and well-being. The analysis also considered the individual, relational, and contextual conditions that may facilitate or constrain these relationships, enabling the integration of different types of evidence without treating each construct as an isolated domain.[13,15]

Differences in conceptual definitions, diversity in operationalization's, and limitations of the available evidence were considered when interpreting the findings. These aspects were used to distinguish established findings from more tentative interpretations and to identify areas requiring further empirical investigation. The final synthesis therefore represents a critical interpretation of the literature rather than an exhaustive or quantitatively aggregated estimate of the available evidence.[11–15]

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The resulting interpretation provides the basis for the discussion of implications for gerontological practice, multidisciplinary intervention, and future research. This methodological approach also recognizes that healthy ageing is shaped by interactions between individual capacities and the social, economic, relational, and environmental conditions in which ageing occurs.[12,13]

Socio-emotional skills, emotional regulation and resilience in healthy ageing

Concept and development of socio-emotional skills

Socio-emotional skills can be understood as a set of capacities that enable individuals to recognize and understand emotional states, regulate affective responses, establish and maintain interpersonal relationships, and respond adaptively to challenging situations.[16,17] Although the concept has been formulated in different ways, an integrative perspective considers these skills as resources that connect emotional, interpersonal, social, and adaptive processes. In ageing, their relevance derives from the fact that adaptation to later life involves not only changes in health and functioning but also transitions in relationships, social roles, motivation, and personal goals. Socio-emotional skills should therefore be understood as potentially modifiable resources associated with adaptation and well-being rather than as health outcomes in themselves.

The concept is closely related to, but not equivalent to, EI; this has been conceptualized as involving the perception, understanding, use, and regulation of emotional information,[16] whereas socio-emotional skills encompass a broader range of interpersonal and adaptive capacities. This broader perspective is particularly relevant to ageing because emotional functioning is embedded in relationships, social participation, and the pursuit of meaningful goals.

A life-course perspective provides an important theoretical basis for understanding how these skills develop and operate in later life. Life-span developmental theory emphasizes that development involves a dynamic interaction between gains, losses, plasticity, and adaptation, with individuals using processes of selection, optimization, and compensation to maintain functioning under changing conditions.[1] From this perspective, ageing is not simply a period of decline but a phase in which previously developed resources may be maintained, reorganized, or compensated for in response to new demands. Socio-emotional functioning may consequently reflect both continuity and change across adulthood.

This perspective is complemented by socioemotional selectivity theory, which proposes that perceived remaining lifetime influences motivational priorities and the allocation of social resources. As individuals perceive time as increasingly limited, they tend to prioritized emotionally meaningful goals and close relationships, which may support affect regulation and emotional well-being.[6,18] Research further indicates that age-related patterns of emotional experience reflect interactions among chronological age, motivation, accumulated experience, and social context rather than age alone.[5,9,20]

Other life-course approaches further emphasize that ageing trajectories are shaped by the accumulation of experiences and resources over time. Individual development is embedded in historical, social, and relational contexts, while transitions and life events may alter developmental pathways. Differences in socioeconomic conditions, education, occupational experiences, family relationships, health, and exposure to adversity may accumulate over the course of adulthood and contribute to divergent trajectories in later life. Consequently, individuals may enter later life with different psychological resources, social networks, health conditions, and opportunities for participation, leading to substantially different socio-emotional trajectories [1,20]. Socio-emotional development can therefore involve maintenance, change, adaptation, and compensation rather than a uniform age-related decline.

This life-course perspective also helps clarify the relationship between individual competencies and the conditions in which they are expressed. Opportunities to regulate emotions, maintain relationships, seek support, and participate socially are influenced by the availability of supportive relationships and environments. Consequently, socio-emotional skills should be considered within, rather than separated from, the broader social conditions that shape ageing.[2,4] The relevant issue is therefore not to attribute healthy ageing solely to individual competencies, but to understand how personal resources interact with social opportunities and constraints.

Chronic illness, multimorbidity, social isolation, poverty, discrimination, and inadequate support may constrain the mobilization and effectiveness of socio-emotional resources. These factors should not be treated as independent determinants, but as interconnected conditions that can influence exposure to stress, access to resources, social participation, and opportunities for adaptation. The relationship between socio-emotional skills and healthy ageing is consequently conditional rather than deterministic.

Overall, socio-emotional skills can be conceptualized as resources that can be developed within life-course processes of adaptation. Their relevance becomes particularly visible during transitions such as retirement, changes in health, bereavement, alterations in functional capacity, and reorganization of social roles. At these points, emotional regulation, interpersonal competence, coping, resilience, and the ability to mobilize social support may facilitate adaptive responses. A life-course perspective therefore shifts the analysis from asking whether socio-emotional skills are simply present in older adults to examining how they develop, change, and interact with accumulated experiences and social contexts over time.

Emotional regulation and resilience in the face of ageing-related changes

Emotional regulation is one of the mechanisms through which socio-emotional skills may facilitate adaptation to ageing and is defined as the processes by which individuals influence the emotions they experience, when they experience them, and how they are expressed.[8] Adaptive regulation does not imply the elimination of negative emotions, but rather the recognition of emotional experiences and the use of strategies adjusted to the demands of the situation.

Among these strategies, cognitive reappraisal is particularly relevant, since the ability to reinterpret a potentially threatening situation may modify its emotional significance and facilitate more adaptive responses. Studies with older adults indicate that positive reappraisal may constitute a relevant coping strategy in the face of adverse situations, including physical health problems.[21] Acceptance may likewise assume importance in the face of events that cannot be completely controlled, such as certain illnesses, functional losses, or irreversible changes.

Illness, pain, and disability represent important challenges for emotional regulation. The presence of chronic conditions or multimorbidity may limit activities, autonomy, and participation, generating fear, frustration, sadness, or insecurity. However, the emotional experience associated with illness is not determined exclusively by the clinical condition. The way in which the person

interprets the situation, regulates their emotions, mobilizes coping strategies, and uses support networks may influence adaptation.[4,20] This perspective is consistent with a biopsychosocial understanding of ageing.

Relational losses constitute another context in which emotional regulation assumes importance. Bereavement, widowhood, the reduction of social networks, and the transformation of family relationships may produce significant distress. An appropriate approach should not, however, confuse adaptation with the absence of distress. Negative emotions may constitute normal responses to significant losses. At the same time, adaptation may involve the progressive integration of the loss, the reconstruction of routines, the maintenance of meaningful ties, and the construction of new goals.[22,23]

Coping is articulated in this context with emotion regulation. It involves cognitive and behavioral efforts to deal with demands appraised as difficult or exceeding available resources.[24] Strategies may include problem-solving, seeking support, reappraisal, or acceptance. In ageing, their effectiveness depends on the correspondence between the strategy used and the characteristics of the situation, with flexibility potentially being more important than the rigid use of a specific strategy.

Resilience should be understood as a dynamic process of adaptation to significant adversity, rather than as a fixed characteristic or an ability to remain unchanged in the face of negative events. The literature on resilience in older people highlights the importance of adversity, responses, and adaptive mechanisms, while emphasising the dynamic and contextual nature of the process.[9] This conception is particularly relevant in the face of illness, losses, disability, economic changes, isolation, and other transitions associated with ageing.

The relationship between emotional regulation, coping, and resilience can be conceptualized as an interdependent process. Emotional regulation may favor more adaptive coping strategies; adaptive coping may facilitate responses to adversity; and the continued mobilization of individual and contextual resources may contribute to resilience and positive adaptation. This relationship should not, however, be interpreted as a rigid causal sequence, since experiences of adversity may also modify regulatory capacities, coping strategies, and perceptions of self-efficacy.

Self-efficacy constitutes another potentially relevant psychological resource.[25] The belief that one is capable of facing certain demands may influence the appraisal of challenges, persistence in the face of difficulties, and the selection of coping strategies. In healthy ageing, self-efficacy may function as a facilitating factor for adaptation, although its effects depend on real opportunities for participation and the conditions in which the person lives. It should therefore not be interpreted in isolation or as a substitute for the objective conditions necessary for adaptation.

Social support represents an essential contextual dimension of resilience. Family, friends, community, and health professionals can provide emotional support, information, practical assistance, and opportunities for participation. The existence of social networks does not necessarily eliminate distress, but it may expand the resources available to cope with adverse situations. Conversely, loneliness and isolation may deplete these resources and increase vulnerability to stressful events.[4,22] Resilience should therefore be understood as a relational and contextual process, rather than exclusively as an individual one.

Purpose and the meaning attributed to life constitute another potential resource for adaptation. Maintaining goals and identifying sources of meaning may help to reorganize life in the face of losses and transitions. The literature indicates associations between purpose in life and various dimensions of health and well-being among older adults, although this construct is multidimensional and influenced by multiple determinants.[26] This dimension brings resilience closer to a broader conception of healthy ageing, in which adaptation involves not only the reduction of distress, but also the possibility of preserving a life perceived as coherent and meaningful.

Consequently, strengthening socio-emotional skills should not be understood as transferring responsibility for adaptation to the older person. The possibilities for regulating emotions, developing coping strategies, or maintaining relationships are influenced by economic, cultural, social, and environmental conditions. A person exposed to poverty, isolation, discrimination, limited access to care, or poorly accessible environments has different resources from those available in a favorable social context. The promotion of resilience should therefore combine strengthening individual resources with the creation of contextual conditions that enable their mobilization.[4]

From this perspective, the first central conceptual mechanism of this article can be summarized as socio-emotional skills; emotional regulation; adaptive coping; resilience; and adaptation, recognizing that these relationships are dynamic, reciprocal, and context-dependent. Socio-emotional skills provide resources for recognizing and managing emotional and relational experiences; emotional regulation may support more flexible responses; coping enables individuals to face concrete demands; and resilience represents a process of adaptation in the face of adversity. The outcome is not necessarily the absence of distress or difficulties, but rather the possibility of developing adaptive responses compatible with the person's characteristics and the conditions in which they live.

Transitions, social participation and mental health in ageing

Retirement, identity and social participation

Retirement is one of the most significant psychosocial transitions of adult life, involving changes in the organization of time, social roles, relationships, identity, and, in some cases, economic conditions. Although frequently associated with the end of professional activity, it does not represent a uniform experience nor does it necessarily produce negative consequences. For some people, it may involve the loss of status, professional identity, recognition, or social contacts previously provided by work; for others, it may constitute an opportunity to develop interests, strengthen family relationships, participate in the community, or invest in activities with greater personal meaning. Adaptation thus depends on the interaction between individual resources, professional trajectory, financial conditions, health, social relationships, and opportunities available during the post-professional period, making retirement less an isolated event than a process of reorganization and adaptation to new circumstances.[27]

In this process, socio-emotional skills may assume a relevant function. The ability to recognize and manage emotions associated with change, communicate needs, reorganize expectations, seek support, and establish new relationships may facilitate adaptation to new roles. However, these competencies should not be interpreted as sufficient or exclusively individual mechanisms. A financially insecure retirement, accompanied by health problems, social isolation, or a lack of opportunities for participation, imposes demands that differ from those encountered in contexts characterized by economic security, social networks, and opportunities for meaningful engagement.[28]

Preparation for retirement should therefore go beyond the financial dimension. It may include reflection on identity, time organisation, social relationships, health, meaningful activities, community participation, and expectations for post-professional life. The literature on preparation and adjustment to retirement suggests that the availability of resources before the transition and the ability to mobilize them subsequently may favor more positive adaptation.[29] From this perspective, competencies such as flexibility, self-regulation, interpersonal communication, problem-solving, and seeking support may contribute to a more adaptive transition, particularly when articulated with favorable social conditions.

The reorganization of time is also a central dimension. The daily structure provided by work may change, simultaneously creating new possibilities and challenges related to routine, autonomy, and sense of purpose. The construction of new routines may help preserve continuity and personal organisation. At the same time, learning activities, exercise, cultural participation, volunteering, family relationships, and community involvement may offer opportunities for development and social interaction.

This perspective brings retirement closer to the concept of active ageing, understood as a process that seeks to optimise opportunities for health, participation, and security, thereby preserving quality of life as people age.[30] Participation encompasses family, community, cultural, civic, and social activities. Community participation, volunteering, and lifelong learning may help maintain relationships, exercise competencies, contribute to collective goals, and preserve feelings of usefulness, belonging, and continuity. Their relevance depends not only on the frequency of activities but also on the available opportunities, health conditions, mobility, economic resources, accessibility, and the meaning these experiences hold for the person.[28]

Intergenerational relationships constitute another potentially relevant dimension. Contact between different generations may favor meaningful relationships, reciprocity, knowledge transmission, and a sense of belonging. Recent evidence on intergenerational programs shows that contexts grounded in shared goals and relationship-building may promote older people's social connectedness, although the effects depend on program design and conditions.[31] For retired people, these experiences may also provide opportunities to maintain or reconstruct socially valued roles, particularly when they enable them to contribute to the community and preserve a sense of belonging and social usefulness.

Social participation, however, is not equally accessible to all people. Barriers related to health, mobility, transport, economic conditions, access to spaces, age-based discrimination, and limited opportunities may significantly limit social involvement. A review of barriers and facilitators of social participation among older adults precisely highlights the influence of individual, relational, community, and environmental factors [28]. Social involvement should therefore be understood as the result of the interaction between individual capacities and the opportunities actually available.

In this context, loneliness and social isolation represent particularly relevant challenges. Although related, these concepts are not equivalent: social isolation primarily refers to reduced social integration or contact, whereas loneliness refers to the subjective experience of insufficiency or dissatisfaction with available relationships. Recent evidence shows that both have a relevant prevalence among very old people and are associated with different sociodemographic, health, and contextual characteristics.[32] The reduction of social networks may result from retirement, widowhood, illness, loss of mobility, relocation, or distancing from family and friends, making an approach that simultaneously considers personal and structural factors necessary.

Digital technologies may support socio-emotional competencies by providing additional opportunities for communication, relationship maintenance, social support, and participation, particularly when face-to-face interaction is limited. Videoconferencing, social networks, educational platforms, and other digital tools may therefore facilitate meaningful relationships and access to activities. Literature reviews indicate that technological interventions may promote social participation and help address isolation, although their effectiveness depends on the type of technology, intervention design, accessibility, and users' digital skills.[33,34] Technology should therefore be understood as a potential resource for the expression and maintenance of socio-emotional competencies, rather than as a substitute for meaningful face-to-face relationships.

Digital inclusion is particularly important because inequalities in access, digital skills, confidence, and accessibility can limit the extent to which technologies support socio-emotional functioning and meaningful participation. When appropriately designed and accompanied by opportunities for access and learning, digital tools may help maintain social connections and facilitate access to support.[35–37] Their value for healthy ageing, therefore, depends not simply on technological availability, but on their meaningful integration into people's needs, relationships, and social contexts.

Taken together, retirement, social participation, and active ageing should be understood as interrelated processes. The transition to retirement may modify roles and relationships; participation may help reconstruct identity, belonging, and purpose; and socio-emotional skills may support the management of the changes and relationships involved. However, these processes are conditioned by economic resources, health, accessibility, social networks, and community opportunities. Active ageing does not, therefore, entail an obligation to remain continuously productive, but rather the possibility of choosing, participating, maintaining meaningful relationships, and preserving a sense of belonging and autonomy.

Socio-emotional skills, depression and psychological well-being

The transitions associated with ageing may also have repercussions for mental health. Illness, pain, disability, relational losses, retirement, economic difficulties, reduced participation, and loneliness may increase psychological vulnerability, although none of these factors individually determines the development of depressive disorder. Depression in ageing should be understood as a multidetermined phenomenon, resulting from the interaction between biological, psychological, relational, and social factors [4]. Consequently, the analysis of socio-emotional skills should avoid any interpretation according to which emotional or depressive difficulties would result from insufficient individual capacities.

Loneliness and social isolation constitute particularly important challenges in this context. Recent evidence shows consistent associations between loneliness, isolation, and mental health in older adults. A systematic review and meta-analysis on the relationship between loneliness, social isolation, resilience, social support, and depression identified relevant relationships between these domains, suggesting that social support and resilience may play important roles in the relationship between loneliness and depressive symptoms.[38] These findings can be interpreted in light of the model developed in Section 3, in which individual and contextual resources are

considered interdependent elements in adaptation processes in the face of adversity.

The relationship between social participation and depression should likewise be understood in a non-linear manner. Reduced participation may contribute to the loss of social contact, decreased opportunities for support, and reduced meaningful experiences, potentially increasing psychological vulnerability. However, depressive symptoms may also reduce motivation, energy, and the capacity for participation, creating potentially reciprocal relationships between the phenomena. This possibility reinforces the need to avoid simplistic causal interpretations and to consider processes over time.

Social support may constitute an important protective factor. Family, friends, community, and professionals may provide emotional, instrumental, and informational support, as well as concrete opportunities for participation. A systematic review and meta-analysis of older adults with depression found favorable effects of different forms of social support, including interventions focused on participation and social networks.[39] More recently, a systematic review and meta-analysis of social support interventions found less consistent results, identifying no statistically significant effects across the interventions analyzed, although recognizing their potential and highlighting the need for further evidence.[40]

Within this framework, socio-emotional skills may function as protective resources without being considered isolated causes of mental health. Emotional regulation may help to cope with negative emotions; interpersonal capacity may facilitate the seeking and use of support; self-efficacy may favour persistence in the face of difficulties; and resilience may contribute to processes of adaptation in the face of adversity.[8,9,25] These relationships should, however, be understood within broader systems of protection and risk.

The prevention of depression in ageing should therefore combine strategies directed at the individual with interventions addressing the contexts in which they live. Evidence on psychosocial interventions shows small but statistically significant effects in reducing depressive symptoms. However, the evidence base for primary prevention remains limited and effects depend on the characteristics of the interventions and populations involved.[41] Prevention should therefore not be limited to symptom treatment and may include promoting social relationships, participation, coping competencies, emotional regulation, and access to community resources.

Positive mental health, however, goes beyond the absence of depression. Healthy ageing also involves life satisfaction, autonomy, positive relationships, purpose, meaning, and the possibility of continuing to develop capacities and interests.[4] This distinction is important because it enables a shift from a logic focused exclusively on disease prevention to an approach that promotes positive psychological functioning.

Psychological well-being can be understood as a multidimensional construct that includes, among other aspects, autonomy, positive relationships, environmental mastery, personal growth, purpose in life, and self-acceptance.[42] In ageing, these dimensions may take different forms depending on opportunities, values, and life circumstances. The aim is not to preserve previous patterns of functioning indefinitely, but to enable the person to reorganize goals and activities in light of the changes that have occurred.

Purpose in life constitutes, in this context, a particularly relevant dimension. The systematic review by[26] shows that purpose in life in older adults is a multidimensional construct associated with different dimensions of health and well-being and influenced by individual, relational, and social factors. Purpose may contribute to organizing priorities, guiding behaviors, and conferring coherence on the experience of life, particularly in the face of transitions that require the reorganization of roles and goals.

Maintaining meaning may be particularly important after retirement, illness, or losses. When previous roles are no longer available, individuals may need to construct new sources of identity and meaning through close relationships, community participation, learning, volunteering, cultural activities, or other personally valued goals.[18,26] Meaningful ageing therefore does not correspond to a single or universal condition, but to the possibility of preserving coherence between values, goals, relationships, and forms of participation.

This perspective is close to the concept of flourishing, understood as a form of positive functioning that goes beyond momentary satisfaction and encompasses dimensions such as positive relationships, purpose, accomplishment, and healthy psychological functioning.[43] A meaningful life may coexist with distress, physical limitations, or losses, provided that the person maintains possibilities for relationships, autonomy, participation, and orientation towards valued goals. Thus, well-being and distress should not be treated as necessarily exclusive poles. A person may experience sadness in the face of a loss and simultaneously maintain meaningful relationships, a sense of purpose, and satisfaction across different dimensions of their life.

Emotional regulation plays an important role here again. The aim is not to eliminate negative emotions but to allow them to be recognized and integrated without impeding the pursuit of relevant goals [8]. Acceptance of circumstances that cannot be fully changed, reappraisal of situations, and flexibility in defining goals may favor adaptation to new living conditions. Thus, emotional regulation links the article's first conceptual axis to the domain of psychological well-being.

The relationship between resilience and well-being should likewise be understood dynamically. Resilience does not mean an absence of distress, nor does it imply that the person remains psychologically unchanged in the face of adversity. It may involve reorganization, partial recovery, the construction of new meanings, and the development of different forms of participation.[9] In this sense, resilience may help preserve or reconstruct conditions that favor well-being, while experiences of well-being and belonging may, in turn, provide resources for facing new adversities.

Social participation thus constitutes a bridge between adaptation and mental health. Participation means not only being physically present but also having opportunities to establish relationships, exercise valued roles, contribute to the community, and experience a sense of belonging. The available evidence suggests that interventions directed towards social support and participation may improve mental health outcomes, although effects vary with intervention characteristics and context.[39,40] This evidence reinforces the importance of considering participation as a dimension of healthy ageing rather than a secondary element.

Digital technologies may also support the expression and maintenance of socio-emotional competencies by facilitating communication, meaningful relationships, and access to social support, particularly when mobility or geographical distance restricts face-to-face interaction. Their potential contribution to mental health is therefore indirect and context-dependent, operating through opportunities for connection, participation, and socio-emotional adaptation rather than through technology itself (Baker et al., 2018; Sen et al., 2022).[33,37]

In summary, the second conceptual axis of this article can be represented as: adaptation, social participation, mental health protection, well-being, and meaningful life. Adaptation to the transitions of ageing may create conditions for the reconstruction of roles and relationships; participation may expand opportunities for belonging, support, and purpose; these experiences may function as protective resources for mental health; and psychological well-being may go beyond the absence of illness, involving autonomy, positive relationships, purpose, meaning, and the possibility of continuing to participate in a life perceived as coherent and valued. As with the first axis, these relationships should not be understood as a linear causal chain, but as dynamic and reciprocal processes, conditioned by the characteristics of the person and the social and environmental contexts in which ageing occurs.

Implications for clinical practice and intervention

The integration of socio-emotional skills into healthy ageing has relevant implications for assessment, prevention, and intervention in gerontological care. These competencies should not be understood as a secondary complement to care directed towards physical health, but as resources that interact with emotional regulation, adaptation to adversity, social relationships, participation, and psychological well-being. An approach of this nature is consistent with a conception of healthy ageing centred on functional capacity and well-being, rather than solely on the absence of disease.[3,4]

Assessment and Intervention Centred on Socio-emotional Skills

The assessment of older people should therefore go beyond identifying diseases and functional limitations and also consider emotional, relational, and social resources relevant to adaptation. An integrated assessment may include difficulties in emotional regulation, coping strategies, levels of self-efficacy, the ability to establish and maintain relationships, social participation, loneliness, available support, depressive symptoms, and indicators of psychological well-being. This assessment should not assume that the presence of difficulties in one of these domains necessarily represents a clinical disorder, but rather allow the identification of risk factors, protective resources, and intervention needs.[44]

Emotional regulation is a potential intervention target, particularly in the face of illness, pain, loss, or changes in functional capacity. Interventions may support the recognition of emotions and the use of reappraisal, acceptance, and emotion-regulation strategies, tailored to the characteristics of the situations.[8] The aim should not be to eliminate negative emotions, but to favor sufficiently flexible responses so that these do not prevent the performance of activities, the maintenance of relationships, or the pursuit of meaningful goals.

The promotion of resilience may likewise benefit from interventions centred on personal and contextual resources. Rather than presenting resilience as an individual characteristic that enables people to overcome adversity, an appropriate approach should consider the interaction between psychological capacities, social support, material conditions, and opportunities for participation.[9] Intervention programs may therefore combine coping skills, problem-solving, interpersonal communication, help-seeking, and goal-setting with strategies to strengthen social networks and opportunities for participation.

Loneliness and social isolation likewise deserve specific attention. Their identification should form part of the assessment, particularly in the face of retirement, widowhood, illness, reduced mobility, or significant changes in social networks. Interventions may include strategies to strengthen existing relationships, create new opportunities for contact and participation, support groups, and community activities. The available evidence suggests that interventions oriented towards social support and participation may produce mental health benefits, although effects depend on program characteristics and the contexts in which they are implemented.[39,40]

Interventions based on mindfulness and other psychological approaches centred on attention to internal experiences may constitute another resource, particularly when integrated into a broader intervention. Their objectives may include developing emotional awareness, acceptance, and the ability to respond less automatically to difficult experiences.[45] However, these strategies should not be presented as universal solutions or as substitutes for clinical interventions when depressive symptoms or other conditions requiring specialized follow-up are present.

Preparation for retirement likewise constitutes an opportunity for preventive intervention. In addition to financial planning, preparation programmes may address identity, time organisation, social relationships, health, meaningful activities, community participation, and the setting of new goals. Early intervention may facilitate anticipation of transition-related changes and support the mobilisation of resources before significant difficulties arise.[29] Programmes involving social participation, lifelong learning, volunteering, and community engagement may further help preserve relationships, autonomy, belonging, and meaning.

Role of health professionals and multidisciplinary approach

The integration of socio-emotional skills into gerontological care requires a multidisciplinary approach. Psychologists, doctors, nurses, occupational therapists, and physiotherapists can, within their respective areas of expertise, contribute to the identification of needs and development of integrated responses. Psychologists may have a particular role in assessing and addressing emotional regulation, coping, self-efficacy, depressive symptoms, anxiety, adaptation to losses, and psychological strategies. Doctors and nurses may contribute to the early identification of emotional and social changes in healthcare settings and to coordination with other professionals. Occupational therapists may support the reorganisation of daily activities, autonomy, and participation, while physiotherapists may help maintain functional capacity and reduce limitations that constrain social participation. The aim is not to assign responsibility for socio-emotional functioning to a single professional, but to ensure that these dimensions are considered in the overall planning of care.[44]

Psychologists may assume particular relevance in the assessment and intervention of emotional regulation, coping, self-efficacy, depressive symptoms, anxiety, adaptation to losses, and the development of psychological strategies. Doctors and nurses may contribute to the early identification of emotional and social changes in healthcare settings and to coordination with other professionals. Occupational therapists may support the reorganization of daily activities, autonomy, and participation, while physiotherapists may help maintain functional capacity and reduce limitations that constrain social participation.

Family and the community should likewise be considered as components of the intervention process. Strengthening socio-emotional skills should not transfer exclusive responsibility for adaptation to the older person. The possibilities of mobilizing personal resources depend on the concrete conditions in which the person lives,

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including access to care, transport, accessible spaces, social networks, economic security, and opportunities for participation.[4] Consequently, effective interventions should combine strategies directed at the person with changes or support in contexts that may facilitate the use of these resources.

This approach also reinforces the importance of early prevention. The identification of changes in participation, increased loneliness, difficulties in adapting to retirement, reduction of social networks, or the emergence of depressive symptoms may enable intervention before more serious problems become established. Prevention should therefore include not only the identification of risk factors, but also the strengthening of psychological, relational, and community resources.[41]

In summary, socio-emotional skills should be integrated into gerontological care as part of a person-centred approach focused on functional capacity, participation, and well-being. Emotional regulation, coping, resilience, social competencies, and social support do not constitute substitutes for medical care or intervention in clinical conditions, but may contribute to how people cope with change, mobilize resources, and participate in everyday life. The most consistent intervention will therefore be one that articulates individual resources, interpersonal relationships, and social and environmental conditions, allowing ageing to be accompanied not only by the management of illness, but also by the preservation of autonomy, belonging, well-being, and a meaningful life.

Current challenges and future perspectives

The integration of socio-emotional skills into healthy ageing represents important advances but also presents conceptual, methodological, and practical challenges. The complexity of ageing, markedcharacterized by heterogeneity in health trajectories, psychological functioning, social resources, and economic conditions, requires models that account for interactions between individual characteristics and life contexts.

Contemporary challenges

A first challenge concerns the heterogeneity of ageing. Older people exhibit very different trajectories in health, social participation, and well-being, and it is not appropriate to assume that chronological age alone constitutes a sufficient indicator of their needs or resources. Resilience illustrates this complexity, as it can be conceptualized and operationalized in different ways depending on the adversity, adaptation, and context.[9]

Cultural differences constitute another challenge. The ways of expressing emotions, seeking support, establishing relationships, participating in the community, and attributing meaning to ageing experiences may vary according to cultural norms, family structures, and social conditions. This diversity limits the automatic generalization of instruments and models developed in a particular context, necessitating greater attention to conceptual and psychometric equivalence across populations.[46]

Socioeconomic inequalities likewise constitute an important limitation. Financial resources, housing, access to care, transport, security, and opportunities for participation condition the possibility of mobilizing psychological and social resources. Competencies such as coping, self-efficacy, or emotional regulation cannot therefore be interpreted independently of the material conditions in which people age.[4]

Ageism, understood as stereotypes, prejudice, and discriminatory attitudes or practices based on age, represents another important social barrier, because it may limit social inclusion and participation. This issue extends to digital contexts, where a recent meta-analysis found a negative association between ageism and digital engagement, moderated by factors such as age, education, and cultural context.[47] Healthy ageing should therefore also be analyzed in terms of the social and digital opportunities effectively available to older people.

Multimorbidity constitutes another relevant challenge. The coexistence of several chronic conditions may limit autonomy, participation, and quality of life and increase psychological vulnerability. A systematic review and meta-analysis found a consistent association between multimorbidity and depression, reinforcing the need to integrate physical and psychological dimensions into assessment[48] Loneliness and social isolation are likewise associated with indicators of mental health and well-being, requiring approaches that consider personal, relational, and contextual factors simultaneously.[32,38]

Digital transformation adds opportunities, but also risks of exclusion. Costs, limited access, insufficient skills, low confidence, and accessibility problems may hinder the use of technologies. A recent review identified the potential of digital interventions to improve technological skills and use, but also highlighted methodological limitations and structural barriers.[49] Digital inclusion should therefore not be confused with the simple provision of technology.

Another fundamental challenge concerns the operationalization of socio-emotional skills and the methodological limitations of research. The diversity of definitions and instruments may hinder comparisons across studies and lead to overlap among EI, emotional regulation, coping, resilience, social competencies, and well-being. In the case of resilience, different ways of operationalizing adversity and adaptation likewise hinder comparisons of results.[50]

Methodological limitations also persist, particularly the frequent use of cross-sectional designs and the scarcity of longitudinal and experimental studies. These limitations make it difficult to establish the temporality of relationships and assess causal processes. Evidence on the effectiveness and sustainability of some interventions also remains limited, warranting more robust evaluations and longer follow-up.

Future priorities for research and intervention

The challenges identified point towards a more personalized, longitudinal, and interdisciplinary research agenda. A priority is to develop interventions tailored to the characteristics, needs, preferences, and resources of different older people, taking into account health, cultural context, economic situation, social networks, and personal goals.

It is equally important to develop integrated programs that articulate socio-emotional skills, physical health, social participation, and psychological well-being. Emotional regulation, coping, resilience, social support, and participation should be considered potentially interdependent dimensions of broader processes of adaptation. This approach should be complemented by prevention strategies across the life course, enabling the development of psychological and social resources before significant difficulties emerge.

Digital technologies and tele-intervention constitute another priority, particularly when they can facilitate access to care, learning, social support, and participation. However, they should respect principles of accessibility and inclusion. Recent evidence suggests the potential of digital interventions, but also heterogeneity of outcomes and the need for more robust evaluations and long-term follow-

up.[51] Artificial intelligence (AI) may likewise support processes of assessment, personalisation, and intervention, but its use should be informed by evidence on effectiveness, safety, privacy, acceptability, transparency, and equity.

Strengthening longitudinal studies and controlled trials constitutes another priority. Studies with multiple assessment points may clarify how socio-emotional skills change over time and relate to life events, health, participation, and well-being. Controlled trials may test which components of interventions produce relevant effects and for which groups.

Cross-cultural research should also be strengthened to distinguish potentially universal mechanisms from culture-dependent processes. At the same time, it will be necessary to assess not only the effectiveness of interventions under experimental conditions, but also their implementation and sustainability in real-world contexts. Collaboration among researchers, professionals, older people, families, community organizations, and policymakers may help bring research, practice, and public policy closer together.

In summary, the future of this field depends on moving beyond a fragmented view of socio-emotional skills and integrating them into a broader understanding of healthy ageing. Research should seek to understand not only whether these competencies are associated with well-being, but also for whom, under what conditions, through which mechanisms, and through which forms of intervention they may contribute to more positive adaptation. In this way, socio-emotional skills can be understood not as exclusively individual resources but as part of systems of adaptation that involve people, relationships, communities, and social and environmental contexts.

The evidence and conceptual contributions reviewed throughout the article can be integrated into a multidimensional framework in which socio-emotional skills interact with emotional regulation, adaptive coping, resilience, social relationships and participation, mental health, and psychological well-being in shaping healthy ageing (Figure 1).

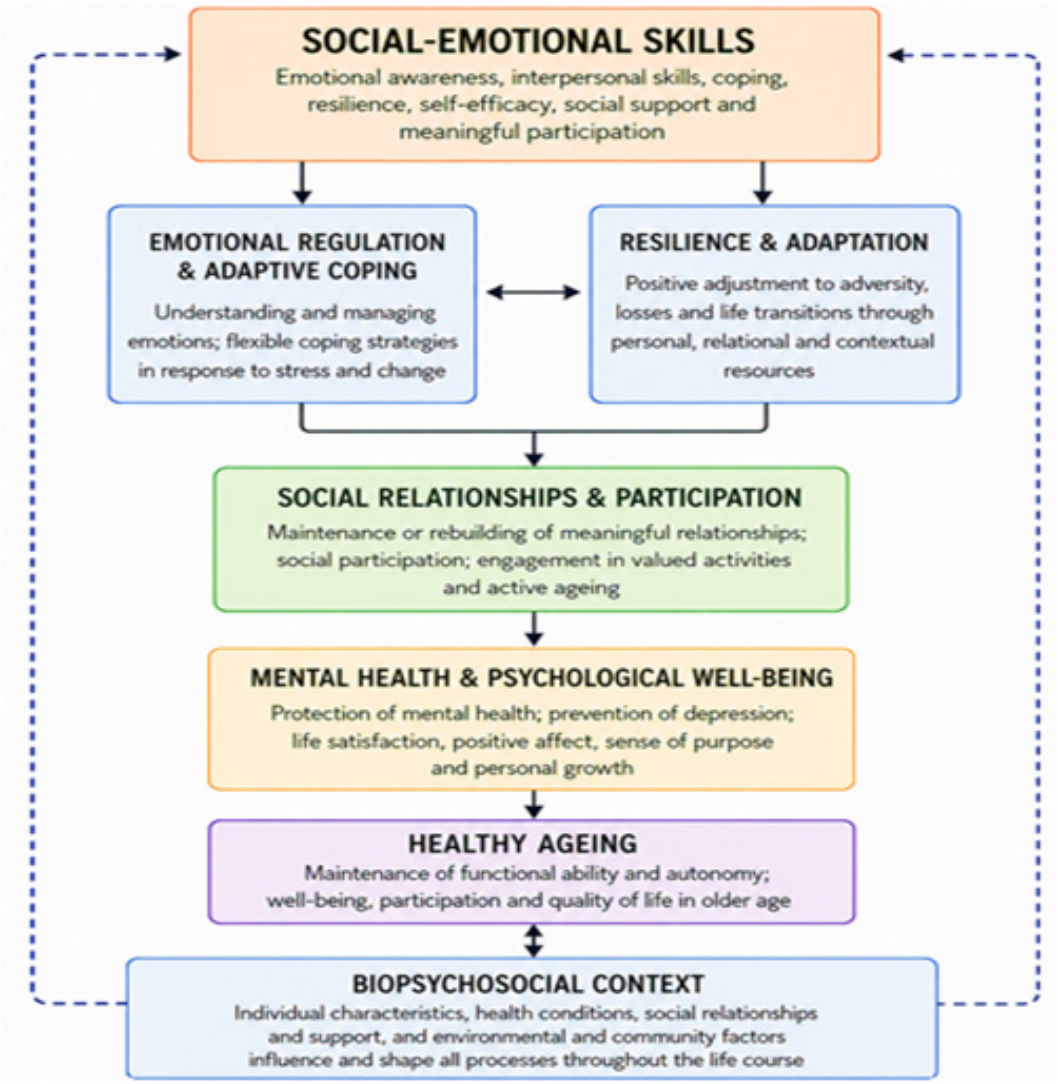

Figure 1 Conceptual model of the role of socio-emotional skills in promoting healthy ageing.

Source: Authors' own elaboration based on the literature reviewed in this article, including[1,2,4,5,6,9,10]

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These relationships should not be interpreted as a linear causal sequence, but rather as interconnected and potentially reciprocal processes embedded within a broader biopsychosocial context. Figure 1 summarizes this integrative perspective and highlights how individual, relational, health-related, and environmental factors may shape and be shaped by these processes across the life course.

Conclusion

Healthy ageing cannot be reduced to the absence of disease, the maintenance of functional ability, or the continuation of particular activity patterns. The central question addressed in this article was whether socio-emotional skills can contribute to healthy ageing and, if so, through which processes. The synthesis indicates that they may contribute by supporting emotional regulation and adaptation, fostering resilience, facilitating the maintenance or reconstruction of relationships and social participation, and, through these pathways, supporting mental health and psychological well-being. These processes are particularly relevant when individuals face transitions associated with ageing, including retirement, changes in health, losses, and the reorganization of social roles and relationships.

The relationships identified in the literature can be conceptualized as an interconnected system involving socio-emotional skills, emotional regulation and adaptation, resilience, social participation, mental health, psychological well-being, and healthy ageing. This framework does not represent a linear causal chain, but rather a system of potentially reciprocal relationships in which individual resources, interpersonal relationships, and social and environmental conditions influence one another. Socio-emotional skills should therefore be understood not as isolated individual determinants, but as resources whose expression and effectiveness depend on the contexts in which older people live.

The main implication of this perspective is that strengthening socio-emotional skills may constitute a relevant pathway for health promotion across ageing, provided that it is integrated into person-centred approaches and articulated with clinical care, social participation, retirement-related support, and community resources. Their strengthening does not replace the structural, social, and clinical determinants of ageing, nor does it transfer exclusive responsibility for adaptation to the individual. It may, however, constitute a modifiable and potentially intervention-relevant resource capable of expanding opportunities to cope with change, preserve or reconstruct relationships, prevent or mitigate depressive experiences, rebuild a sense of purpose, and participate in a life perceived as autonomous, meaningful, and valued.

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Conflicts of interest

The authors report no potential conflicts of interest relevant to this article.

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