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Article

Addressing Social Isolation as a Potent Killer!

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Introduction

Social isolation is a major health problem that has not received enough attention. The AARP Foundation recently reported that social isolation is a growing epidemic in America affecting over eight million older adults (AARP Foundation, 2016). Social isolation has been linked with a wide array of health problems, including cognitive impairment, poor self-rated health, neglect of desired health practices, ability to survive a natural disaster, and also mortality (Berkman, 2009; Crooks, Lubben, Petitti, Little, & Chiu, 2008; Eng, Rimm, Fitzmaurice, & Kawachi, 2002; Ertel, Glymour, & Berkman, 2008; Holt-Lunstad, Smith, & Layton, 2010; Lubben et al., 2006; Pantell et al., 2013; Pekovic, Seff, & Rothman, 2007; Schnittger, Wherton, Prendergast, & Lawlor, 2012; Zhang, Norris, Gregg, & Beckles, 2007). It has been suggested that social isolation is as bad for one's health as smoking 15 cigarettes a day (Holt-Lunstad et al., 2010; Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015).

Social isolation is a major health problem that has not received enough attention.

There are various reasons given to explain why strong social ties are so important to health. These explanations can generally be assigned to one of three overall theories. The first theory is that social ties provide essential support at times of illness, either helping one recover more quickly and more safely from an illness or to get to medical attention more quickly (Berkman, Glass, Brissette, & Seeman, 2000). Essentially this body of research argues that social ties are important because of the social support component. A second theory states that social ties are important because they encourage people to adhere to better health practices (Umberson & Montez, 2010). It is argued that strong social ties help a person give up bad practices such as smoking or adopt good health practices such as better nutrition. A third theory looks at a possible causal link between social ties and the immune system. This theory includes extensive research examining how social ties may buffer the impact of stress (Thoits, 1995). More recent attention has focused on identifying markers of accumulated stress and explicating possible mechanisms by which strong social ties might simulate the immune system and thus help deal with the slings and arrows that one inevitably encounters over the life course (Seeman, Singer, Ryff, Dienberg Love, & Levy-Storms, 2002).

Identifying Social Isolation Among Older Persons

The central question is determining what aspects of one's social connections should be measured, and what dimensions or perceptions of those relationships were particularly relevant for predicting subsequent morbidity and mortality. When measuring social isolation, it is essential to be fully aware of the focus of the assessment. The focus identifies the potential target of interventions to eradicate the social isolation condition.

Primary social groups, namely family, friends, and neighbors, are the mainstay of social ties, particularly in youth and old age. Family is generally considered the most

central primary group to which an individual belongs. However, intimate friends can also be as vital as family ties, especially when family relations are strained or deficient for other reasons. Alternative family arrangements and the formation of non-married couples—especially as social norms and practices around family formation change—impart new complexity to quantifying social connections. Secondary social groups include membership organizations such as recreational or culture clubs, professional societies, and a wide array of other organizations, including political and religious groups. The workplace is an important forum for social relationships and, for individuals who are otherwise isolated, can serve as a regular form of social contact and connection.

The distinction between primary and secondary social groups is relevant for understanding major approaches to measuring social isolation. For example, many social researchers tend to examine social networks through a lens measuring participation in social activity and organizations. Meanwhile clinical researchers have largely focused on primary social groups. The Social Network Index (Berkman & Syme, 1979), a common instrument in public health research, is a classic example of a measure emphasizing secondary social groups (clubs, organizations, etc.). The Lubben Social Network Scale (Lubben et al., 2006) is an example of a measure of social isolation focused on primary group membership (family, friends, neighbors) and so it has found favor with practitioners and clinical researchers.

An older adult's self-perception of isolation is yet another potential focus for the assessment of social isolation. Indeed, some have suggested that measures of loneliness can be viewed as perceived social isolation (Hawkley & Capitanio, 2015). This reconceptualization of loneliness as a measure of social isolation provides exciting possibilities to blend the knowledge gained from the social network/isolation literature with that of the loneliness literature.

What Can be Done About Social Isolation?

So how can we address social isolation as a potent killer in social policy, clinical practice, health research, and even in our own personal lives? Here are some recommendations. In terms of policy, we need to develop communities that foster and support building strong social ties as opposed to creating social barriers that might inhibit the development of ties. For example, the village models of age-friendly communities attempt to fabricate new social ties to replace those lost or frayed among older adults unable to remain in their long-term communities as they age (Scharlach, Davitt, Lehning, Greenfield, & Graham, 2014).

Another important policy change would be for Medicare to start covering hearing aids and examinations. There is strong evidence that severe hearing loss contributes to social isolation. However, prescribed hearing aids are very expensive. Recently there was legislation approved that instructs the Food and Drug Administration to test the safety and effectiveness of over-the-counter hearing devices. These devices, known as Personal Sound Amplifiers, are not currently regulated as strictly as prescribed hearing aides. It is hoped that higher-quality Personal Sound Amplifiers might enable those who cannot afford a prescribed hearing aid to gain some improvement to their hearing.

We need to invest in a public education campaign bringing attention to the seriousness of social isolation. For example, the American Academy of Social Work and Social Welfare announced in January of 2016 that eradicating social isolation was one of the 12 grand challenges for America to address over the next decade (AASWSW, 2016). In November of 2016 the AARP Foundation announced the *Connect2Affect* campaign to draw attention to social isolation (AARP Foundation, 2016). Boston College Institute on Aging has produced a series of free videos on social isolation that can be employed in educating health professionals as well as the general public (Boston College Institute On Aging, 2017).

In terms of practice, it's high time that we develop geriatric protocols that include the assessment of isolation as part of the protocol for geriatricians, geriatric nurses, social workers, etc. Just as health professionals check on people's weight, blood pressure, smoking, and so forth, they need to start screening for social isolation. Not only will this change in practice protocols enable the identification of high-risk individuals for whom interventions may be developed, but it will also send a strong message to all patients that preventing social isolation is important to maintaining good health. In addition, we need to develop and test interventions designed to reduce the risk of social isolation. A critical question is how to nurture the development of strong social ties where they do not exist.

It's essential that we seek to better understand how and why social ties are such a strong factor in people's health and well-being. Accordingly, it is critical to foster more intervention research on social isolation. There are different causes of social isolation and so it's unlikely that one approach is going to fit everybody. Thus, we'll need to tailor interventions depending on the etiology or the cause of the isolation. In addition, there is a need for an inventory of successful interventions that can be shared with the policy and practice communities.

Much attention has been given to planning for retirement. However, retirement planning should also focus on building social capital. We've developed whole industries devoted to enhance the likelihood that one enters old age with a retirement nest egg of savings to provide financial security, and it's just as important that one attend to building social capital. Many people come to grips with this as they start to shift away from child-rearing responsibilities and busy careers. It is then that people often realize that they invested too little, too late in strengthening personal relationships. This happens in part because our society

has promoted the myth of rugged individualism, which is counter to reality. Frankly, we all get through life with help from our family and friends who nurture us during critical points in our lives.

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Conclusion

The scientific evidence is a convincing. Strong social ties are good for one's health. Paraphrasing the Beatles, we do indeed get by with more than a little help from our friends, our family, our neighbors, and others. Strong social relationships are essential for a good life. The consequences of neglecting this fact become especially apparent in old age. Thus it is urgent that more attention be given to social isolation as a potent killer.

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