SOCIAL ISOLATION AND LONELINESS AMONG SENIORS

Pamela Krist Atwood, MA, CDP; Ted Moore, CFO; Lisa Germano, LMT

We spend our lives building family and social networks of such extent that we sometimes need to get away to reclaim a bit of solitude. While we cannot choose family, we tend to elect our friends and are able to regulate the number, frequency and quality of our social relationships in much the same way we regulate our appetites. If we are too selective however, it may have a profound impact on our so-called "golden" years. Recent headlines cry "Loneliness is the New Smoking" as research identifies the health effects of loneliness and social isolation on seniors, and equates the effects to those of smoking 15 cigarettes a day – effectively shaving 8 years off one's life.

As we grow older, our ability to maintain the kinds of social contacts we had grown accustomed to naturally contracts. Senior Americans become less mobile, particularly driving, lose friends, children move and socializing can become too taxing to those with declining health. Consequently, older adults can become socially isolated and are prone to developing chronic loneliness. Even couples, with one suffering significant health issues and/or disabled from engaging in meaningful companionship, are prone to becoming lonely.

Loneliness and social isolation are often viewed as synonymous yet gerontologists almost universally agree that they are distinct conditions. Loneliness is generally understood as the discrepancy between a person's preferred level of social contact and their actual level of social engagement. Social isolation is defined as an objective state of having minimal social contact. Loneliness is a subjective, unpleasant feeling in which the person yearns for intimate companionship or social connectivity. Social isolation is an environmental condition influenced by such personal circumstances such as lack of transportation minimal contacts, and declining health.

Physical immobility and physical isolation does not automatically result in loneliness. Many home-bound seniors are well-socialized through phone contacts, friendly visitors or home care companions/aides and, more and more, through technology/internet. Nonetheless, access to friends is often limited by changes common in aging: death of spouse/partner/friends, moving to be closer to adult children, physical immobility, hearing loss (making phone calls more difficulty), visual deficits, stigma related to diagnosis or socio-economic status, or lack of social opportunities secondary to retirement (i.e. many of our friends are from our work-life).

Untreated, social isolation can lead to sensory deprivation. Since the 1960s researchers have examined the link between social isolation and the negative outcomes of sensory deprivation, such as cognitive impairments, delusions and hallucinations. The connection should be no surprise, since "solitary confinement" is one of the gravest punishments allowed throughout the US Departments of Corrections. Overall, people with social isolation maintain a very low quality of life.

Left unmitigated, chronic loneliness and social isolation can accelerate declines in overall health and well-being. There is sizeable literature which holds that chronic loneliness is associated with depression, decreased physical activity, impaired functioning, worsening dementia, and lower subjective well-being. Research has confirmed that social isolation can have detrimental effects on health with outcomes like those of smoking, lack of exercise and high blood pressure. Both conditions have been shown to increase the risk of all-cause mortality and morbidity. How can aging services providers assist older adults to combat loneliness and social isolation?

OPPORTUNITIES & THREATS

There are many interventions or solutions known to be effective in alleviating the negative effects of loneliness and social isolation in later life. Senior living community staffs, as directors of social models of care, must be at the forefront in identifying and reducing isolation as part of the core mission of assisted living. Seniors should be assessed using assessment tools proven reliable for identifying conditions of loneliness and social isolation and depending on the magnitude of the problems, referred to appropriate settings whether clinical to treat depression, community settings to increase opportunities for socialization or to other settings which can address any maladaptive behaviors such as social withdrawal or anxiety which often arise after prolonged exposure to being socially isolated.

Social workers, recreation therapists, and other health professionals which specialize in geriatrics have developed many solutions over the years. Today's seniors have many opportunities to combat social isolation and loneliness. Throughout our country, we have programs and services supported by the Administration on Aging, such as senior centers, congregate meal programs, Retired Senior Volunteer Programs, Area Agencies on Aging for resources and referrals, as well as private programs in many communities.

Senior living offers immediate relief from social isolation, but the abrupt shift from solitude to a socially rich environment can be overwhelming and will likely do little to combat loneliness until interventions which specifically target loneliness are also introduced. Senior living staffs who are asked to assess a prospective resident for diminished quality of life from either chronic loneliness or prolonged social isolation should begin with a thorough assessment which addresses both conditions. In building a factual case for social isolation, examiners should probe the prospect on the number of social contacts they have daily, and the frequency of those contacts. The prospective resident should be asked to identify all social activities they engage in, all social clubs to which they belong, and explore the nature of their relationships. By asking follow-up questions such as how long has it been since you have driven to the store, or when was the last time you played bridge, the examiner can draw conclusions as to whether a person has become socially isolated and why. The examiner should ask prospects about the quality of relationships and draw conclusions about whether the prospect is lonely and why. Since a high number of seniors are affected by cognitive disorders, a knowledgeable caregiver should also be interviewed to verify the assessment and determine patterns throughout the individual's lifespan.

CASE EXAMPLES: (*names and immaterial details changed for privacy)

Judy* loved golf and tennis. She was always involved in social networks, her friends, the parents of the PTO and Girl Scouts when the kids were little. Her daughter noticed changes when there was a rotator cuff injury. Judy had always been a people person, but found herself isolated. She gave up golf and tennis. She occasionally visited some of her friends, so she denied being lonely. Her daughter noticed Judy having wine every night though (a change from the past). Her daughter became (rightly) worried about Judy's risk of falling, along with loneliness and social isolation.

James* lived in a rural town in CT. He had farmed his land for many decades and was involved in his local church. After his family encouraged retirement, he allowed the senior center to provide some supportive services, but he was rarely engaged in structured programs. After a while, it was evident that his thinking and judgment were changing, and he was eventually diagnosed with a progressive neurodegenerative disorder (dementia). He was appointed a conservator and admitted to a nursing home. James had a very difficult time adjusting because his dementia had progressed to a point where he was unable to maintain a meaningful conversation with peers. He participated in activities with staff, but soon became ill and passed away, within 4 months of his admission.

Dee* lived in a three-story private house in Boston's Back Bay. She and her husband raised their two boys there, although he had passed away in 1990 after a battle with cancer. Dee's sons moved to nearby states. Her friends started to leave the city, moving out of state to be closer to grandchildren, or moving to assisted living facilities for more health monitoring. Dee was always very social in her established network, although not always comfortable independently making new friends. Complex symptoms (later diagnosed as Parkinson's) resulted in isolation and, despite having a car and the ability to drive, she was unable to get out and about easily. In 2015, Dee started to consider moving too, for a variety of physical and practical reasons. With her family, she chose to move to an independent and assisted living facility in CT near one of her sons and grandchildren. With professional help to downsize and plan the move, Dee settled into her new 2-bedroom apartment quickly. Within six months she was established with new friends, and stated, "I have more friends now than I've had in my entire adult life."

ASSESSING THE SITUATION

Recent changes in Medicare have included an annual cognitive assessment at the Wellness visit of someone over age 65; and in 2017 a new provision for billing care planning meetings was added for physicians and APRNs. Few seniors report having these assessments though, so a *lack of* diagnosed dementia, depression or social problem should not indicate a senior is "fine."

Standard assessments for older adults include the PHQ2 (two simple questions to evaluate if more assessment of depression is indicated), and the PHQ9 (9 questions). Also, a Geriatric Depression Screen is a simple tool to identify depressive symptoms. The Mini-Cog can give a picture of whether memory disorders may be influencing outlook. None of these tests is diagnostic alone. A "positive" result on any should lead to an immediate medical evaluation for diagnosis and treatment if appropriate.

Reliable assessment tools for loneliness and social isolation include the UCLA Three-Item Loneliness Scale or the Six-Item DeJong Gierveld Loneliness Scale. Each draws out both loneliness and social isolation. Neither asks whether a person feels lonely which can evoke a defensive answer, but the UCLA Scale asks, "How often do you feel isolated from others?": the six-item scale asks whether there are enough people around if the person encounters a problem. The follow-up inquiry for persons who score high for loneliness or social isolation, is whether prolonged isolation has caused maladaptive behaviors such as withdrawal or social anxiety. Social isolation can create a feeling of helplessness, and this can exacerbate anxiety, causing further withdrawals. The examiner who discovers maladaptive behavior should probe whether this is a change for the individual or part of a lifelong challenge.

Although most lonely seniors do not go to extremes, the risk of suicide is not reserved only for angst-filled teenagers. Depression in elders is under-detected and often under-treated and suicide rates among the elderly are increasing. Risk factors increase if there is a history of substance abuse, chronic illness, pain, dependency for care, and isolation. Suicide in seniors is rarely impulsive though; most contemplate it for a long time before acting. Experts say that asking if someone thinks about suicide does not trigger it. If any clinician believes a person is having suicidal thoughts, 211 is a free service throughout the United States and most of Canada, including a suicide prevention and mental health crisis line. Ongoing psychiatric support services should be included in senior living communities.

INTERVENTIONS

Absent mental illness, most people who are socially isolated can be supported with some simple interventions and attention to the issue.

Finding New Friends

The best approach to assisting seniors who move into senior living from a socially isolating environment, and are chronically lonely, is for staff to introduce the resident to the number and frequency of social engagements more slowly, often meeting with and mentoring the new resident. Interventions to combat loneliness includes befriending-introducing residents to others who share similar interests can consummate friendships; one on one coaching and one on one social skills building can increase confidence while reducing social anxiety: educational discussions on the importance of maintaining good friendships which can induce residents to be more conducive to making friends; and studies have shown that reminiscence therapy – finding meaning in memories – can be effective in alleviating feelings of loneliness and depression particularly in men.

Finding Something in Common

Reminiscence therapy is a common strategy used in nursing homes, and can easily be applied to all senior living communities. Seniors can connect about the year they graduated high school, favorite movies or political debates. Many elderly clients enjoy retelling a story about competing with friends to produce the shiniest chestnuts, or being the first to test the pond ice in December, or what one saw when strolling to the snack bar at the drive-in movie on a Saturday night. These are small snippets of life unique to older generations which can induce even the quietest seniors share their past. This is the quality of dialogue which can make

profound differences on whether a person can mitigate if not eliminate their chronic loneliness.

Finding New Purpose
One of the 7 Dimensions of Wellness is vocation. When anticipating retirement, many people wonder what they will do with all their "free time." Finding a sense of purpose, a way to give back to the community or the next generation, and sharing one's own wisdom are natural and necessary parts of human development in later life. In senior living, staff need to support this need by creating opportunities and community connections for seniors to explore. Some may volunteer with Retired Senior Volunteer Programs, reading to youth in schools, or engaging in community gardens to support a local food pantry.

Finding Wellness
Social isolation is frequent among people who are physically frail and have limited mobility. Therefore, physical exercise and specific fitness goals can help people combat isolation. Senior living communities need to intentionally build opportunities for clients to exercise and be physically fit, beyond Medicare-covered physical and occupational therapy. Although assisted living facilities work in a social model of care, we also need to address medical issues which impact socialization, such as hearing and vision. Regular wellness services such as massage, Tai Chi or Qi Gong, and complimentary therapies should be built into activities and a' la carte services. Wellness should also include spirituality and intellectual stimulation. Emotional support can be facilitated through a variety of interventions such as laughter therapy, support groups or bereavement workshops.

Finding People Who Care
At Colebrook Village, we believe that people who work in senior living are driven to make a difference in the lives of the older adults they serve. Knowing how to make a difference can be elusive amongst the competition and mission vs. margin debates in the "industry." By focusing on issues such as loneliness and social isolation, and taking a deep dive into such topics, we can be authentic in our drive to reduce one of the Eden Alternative's "plagues of aging." Training staff to recognize signs and symptoms, assessing the needs, and customizing person-centered interventions helps staff make a positive difference in our residents' lives.

For people seeking senior living, we recommend shopping as if you are visiting colleges. Each campus has a different feel and offers a different blend of academics, social activities and environment. This is a great comparison to senior living communities. Furthermore, each financial aid office offers differing levels of support to find ways to manage the associated expenses.

For people working in senior living we have found organizations that support our mission, such as the International Council on Active Aging. We are building our program on their 7 Dimensions of Wellness. Our *Wellness 4Later Life* program ensures that industry best practices and vision for positive aging meet our drive to support residents' needs fully.

This article was written collaboratively by the staff at Colebrook Village at Hebron. If you or someone you know has loneliness or social isolation visit us at 105 Main Street, Route 66 in Hebron or call us at 860-801-1114 or www.ColebrookVillage.com for more information.

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RESOURCES

InfoLine - dial 211 or on the web, www.infoline.org

Area Agencies on Aging – www.n4a.org

Alzheimer's Association – 800-272-3900 or www.alz.org

Senior Centers and Senior Services – www.ncoa.org

International Council on Active Aging – www.icaa.cc

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