Social isolation among older persons is a long-standing problem, and, according to the AARP Foundation (2012), it places millions of Americans at risk of poor health and prolonged loneliness. Despite the severity of the problem, inadequate attention is given to it, probably because it seems to be so obvious that we assume it is on all of our radars. Too often it seems that social isolation among older persons is hidden in plain view.

Yet, there is convincing evidence that our knowledge about this serious concern has not adequately been transferred to practice.

My rekindled emphasis on social isolation was fueled by an article I read that indicated that loneliness is as deadly as smoking cigarettes and obesity. Public Health Watch (2015) reports on research by Dr. Tim Smith and Dr. Julianne Holt-Lunstad that found “loneliness poses a substantial risk of death—similar to smoking 15 cigarettes a day or being an alcoholic. The study says that risk surpasses that posed by obesity” (p. 1).

I don’t know about you, but this was eye-opening and elevated my concern. While public campaigns have made us very familiar with the health hazards of cigarette smoking, obesity, and alcohol, we have remained relatively silent on the equally deleterious effects of social isolation and loneliness on the lives of older persons. The short yet powerful message is that loneliness and social isolation kills; however, it does not have to if we as a profession take collective action to address it in the various practice arenas where we work.

Whether we practice in health care settings, housing, social services, private practice, or other areas, with focused attention, we can improve the quality of life of many older persons by paying attention to social isolation and sharing effective strategies that we have used.

I ask that we each search our professional selves and think about lessons we have learned and use them to share with others—especially our newer social work colleagues. For example, I recall that more than 20 years ago, when I was an executive director of public housing, I read an article that emphasized the value of a front porch in reducing crime because it reduced isolation and promoted neighborliness. In a recent conversation with the department head of architecture at our university, I shared my interest in working with her to focus on the built environment as a strategy to reduce social isolation or promote social engagement.
She acknowledged that front porches have indeed resurfaced in design. In researching this, I found several articles that confirm the value of the built environment. According to Srinivasan, O’Fallon, and Dearry (2003):

Mounting evidence suggests that there are social, health, and economic consequences to isolated and sedentary lifestyles. Unfortunately, the physical and social construct of the urban environment promotes isolation. Higher rates of television viewing, increased computer usage, concern about crime, little contact with neighbors, and geographic isolation have created communities that are not interconnected. This isolation may result in a lack of social networks and diminished social capital, which can contribute to obesity, cardiovascular disease, mental health problems, and increased rates of mortality (p. 1446).

Additionally, in a Sacramento blog, Linguist (2012) describes the front porch as a “neighbor magnet” that addresses our isolated society through built environments that build relationships.

My professional radar was also triggered by a conversation with an older friend who reminded me of how difficult it was to watch her network of friends dwindle. She said it seems that “the only time my telephone rings now is when there is news of another death.” She also said, “I use to get calls all the time, and now I can count them on one hand during the month.” Upon hearing this, I immediately became more sensitive and started making monthly calls to catch her up on things going on in my life. This is a simple, yet effective tool for reaching out to older persons who we care for and about. While we cannot replace the lost friends, we can fill in the spaces.

Literature confirms that multiple losses resulting in small social networks (Cornwell & Waite, 2009) are clearly associated with high levels of social isolation (AARP Foundation, 2012) and contribute to the growing challenges that social workers will face in addressing social isolation and loneliness. (Many articles on depression, grief, and loss provide more context for this.)

Much has been written about the increased longevity that Americans, and those in other countries, will enjoy. A rise in family caregivers is an outgrowth of the increasing number of older persons in society. According to a recent AARP Report, Caregiving in the U.S. 2015: Focused Look at Caregivers of Adults Aged 50+, there are a substantial number of older family caregivers of older relatives. According to the report, “Those providing care to the oldest-old—that is, those who are 85 and older—are themselves older. They are less likely to be working and have been providing care longer” (p. 7). Older caregiver-care receiver dyads have multiple critical dimensions and social isolation of the caregiver is among them.

In closing, Perlman and Peplau (1981) describe loneliness and its resulting social isolation as what happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want. I like this definition because of its clarity of what is needed to address social isolation. Social isolation is one...
providers and older adults alike, behavioral health promotion and older people.

of the 12 social work grand challenges, according to the American Academy of Social Work and Social Welfare (2016). This group calls for the education of the public on social isolation as a health hazard, and “encourage[s] health and human service professionals to address social isolation, and promote effective ways to deepen social connections and community for people of all ages.” As concerned members of the aging network, I urge social workers to focus on social isolation as a priority and to contribute to solving this problem in the next 10 years. I am confident that our collective focus will make life better for many and we will honor our core value of dignity and worth of all persons.

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REFERENCES


RESOURCES

Campaign to End Loneliness www.campaigntoendloneliness.org/about-loneliness/

Upcoming Live Specialty Practice Sections Webinars

Challenges and Complexities of Cultural Competency in Social Work Practice
Tuesday, October 18, 2016 • 1:00 PM - 2:00 PM ET • 1 Cross Cultural CE Contact Hour

The Role of Social Workers in Goals of Care Conversations with Seriously Ill Patients
Tuesday, November 15, 2016 • 1:00 PM - 2:30 PM ET • 1.5 Social Work CE Contact Hours

Beyond Treatment As Usual: The Case for Cognitive Remediation
Tuesday, December 6, 2016 • 1:00 PM - 2:00 PM ET • 1 Clinical CE Contact Hour

Developing Cultural Humility in Social Work Practice
Tuesday, January 31, 2017 • 1:00 PM - 2:00 PM ET • 1 Social Work CE Contact Hour

The 3 S’s: Supervision, Self-Reflection, and Self-Care
Tuesday, February 7, 2017 • 1:00 PM - 2:30 PM ET • 1.5 Social Work CE Contact Hours

More live webinars coming soon including an ethics webinar in March visit socialworkers.org/sections for details.
ADDRESSING SOCIAL ISOLATION AMONG OLDER PERSONS

Family caregivers provided care valued at approximately $375 billion in 2008 (AARP, 2008). The amount increased to $450 billion in 2009 (AARP). Family caregivers are often not fully informed about the patient’s prognosis and the daily challenges associated with caregiving (Mangan, Taylor, Yabroff, Fleming, & Ingham, 2003). It is imperative that caregivers have a voice in the development of care plans for their patients and themselves. If caregivers are actively involved in the interdisciplinary team meeting, they would be able to share both their and their patients’ concerns.

Family Group Conferences (FGCs), defined as semi-structured gatherings that recognize the value of extended family support, open up the lines of communication, and allow the care team and families to work together (Brodie & Gadling-Cole, 2003, 2008). These authors assert that an essential component is to bring all necessary support systems together using FGCs, which foster caregiver involvement in the creation of a care plan that supports both the caregiver and patient. Cattan, White, Bond, and Learmonth (2005) found that educational and social activity group interventions that target specific groups can diminish social isolation and loneliness among older people. This will also positively impact their caregivers due to increased social supports.

DEMENTIA AND LONG-TERM CARE

Kaplan and Berkman (2011) found that implications of global aging for health and aging professionals must be addressed, particularly for those who suffer from a dementia-related disorder. Dementia is a major public health problem with tremendous costs to society (Joling et al., 2008). The long-term nature of dementia caregiving requires long-term support strategies oriented around the various transitions that emerge in the context of the caregiving career. Institutionalization of an older adult relative suffering from various forms of dementia is a primary transition in the caregiver career (Burton, Zdaniuk, Schulz, Jackson, & Hirsch, 2003; Gaugler, Zarit, & Pearlurn, 2003; Pot, Zarit, Twisk, & Townsend, 2005). Research indicates that clinicians must recognize that whenever services are provided, family caregivers must be incorporated as full partners in care (Strang, Koop, Dupuis-Blanchard, Nordstrom, & Thompson, 2006).

Research also suggests that providing family-level support with an emphasis on family-staff care partnerships or education during and immediately following a relative’s entry to a nursing home (NH) is most beneficial (Gaugler, Kané, & Newcomer, 2007). There is a need for intensive support targeted to those time periods when families may be most at risk for negative outcomes such as depression, which is often triggered as a result of social isolation. Such support could maximize the families’ abilities to remain effectively involved in the life of the resident during and after the transition to NH care (Gaugler, Pot, & Zarit, 2007).

FAMILY GROUP CONFERENCES AND NURSING HOMES

Placing a loved one in an NH is an extremely stressful event (Pillemer & Meador, 2006; Schmall & Stiehl, 2003). Though it is often assumed that the family’s involvement ends when the relative is placed in an NH, research shows that family caregivers continue to interact with and provide care for older adults that are in NH care (Pillemer & Meador, 2006). Involvement of caregivers in NH is beneficial for the residents; however, difficulties experienced by both families and NH staff can result in strained relationships, as well as decreases in the caregiver’s involvement with the care recipient and increases in social isolation. Caregivers often have negative stereotypes about NHs and fears about the quality of care that their loved one will receive. There are fears of retaliation by the NH staff if they address concerns or that they will be asked to seek care at another facility (Pillemer & Meador, 2006).

Many nursing homes routinely invite residents and their representatives to attend care conferences. When changes in a resident’s needs are identified, the care plan must be revised to address those needs. Brodie and Gadling-Cole (2003, 2008) assert that when these meetings are conducted properly, they offer an opportunity for the caregivers, patients, and multidisciplinary
and their caregivers is an issue of making primary caregivers inclusive in the decision-making process. Including the primary caregiver and perhaps members of the extended family in interdisciplinary case management meetings is an innovative approach to collaboration (Brodie & Gadling-Cole, 2003, 2008). Brodie and Gadling-Cole (2008) assert that FGCs can serve as a forum to recognize the value of extended family members, open up the lines of communication, and allow service providers, older adults, and families to work together in an NH setting. Perhaps the FGC model can be a means of decreasing caregiver burden and improving the caregivers’ perception of quality of care.

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REFERENCES


RESOURCES


The following case scenario brings attention to how social isolation is related to grief and loss.

Mary Brown is a 70-year-old widow and recent retiree. She has two children, both of whom live hundreds of miles from her. Four years ago, upon the retirement of her husband, the couple moved from their city home where they had lived for 45 years. He died unexpectedly three years ago at age 70. Mr. Brown had been an outgoing extrovert who had a large cadre of friends, while Mrs. Brown had always been more reticent and introverted; her husband's friends were her friends. Now that he had died, she found herself no longer in contact with them as they discontinued reaching out to her soon after his death. Due to her history of major depression, experienced since early adolescence, Mrs. Brown has had difficulty forming relationships as she was often hospitalized due to her illness. Furthermore, her family had moved several times during her father’s military service. The new senior housing community to which the couple had moved was 25 miles from Mrs. Brown’s place of employment and since she did not drive, Mrs. Brown utilized a commuter bus service to get to work, where she felt a sense of accomplishment and pride. Her co-workers had been the only social support system outside of her immediately family. Mrs. Brown was recently forced to retire because of her deteriorating hearing and arthritis, which made it difficult to manage getting on the commuter bus; and her recurrent depression, for which she had experienced once again after her husband’s death and her retirement. These conditions also contribute to her refusal to travel to visit her children, and their jobs and family obligations preclude them from visiting often. Since retirement, Mrs. Brown has become more and socially isolated.

This case scenario, unfortunately, is not an unusual one for many older adults. According to Biordi and Nicholson (2012), “social isolation is the distancing of an individual, psychologically or physically or both, from his or her network of desired or needed relationships with others persons” (p. 85). Older adults may become socially isolated due to experiences of loss and grief.

Simos (2000) identified four categories of loss: loss of significant others, which may result from death, divorce, abandonment, geographic moves, and so on; loss of part of self, with subcategories of physical loss, psychological loss, social role loss, or cultural loss; loss of external objects such as loss of housing or income; and developmental loss, which may result in the aging process itself. Social isolation may be manifested in each of these categories of loss. While some individuals may experience loss in only one or two of these categories, others may experience loss in each category and these losses may overlap. It is likely that the more categories of loss one experiences, the more socially isolated one may become.

As one ages, the loss of significant others can contribute to loneliness and social isolation. Older adults often experience the death of loved ones or friends, lose connections to former co-workers due to retirement, or family connections due to geographic moves. In the case of Mrs. Brown, her loss of significant others was experienced in the form of the death of her husband and subsequent isolation from his friends, distance from her children, and forced retirement. As a result of her unplanned retirement, Mrs. Brown had few supportive local connections left.

Loss of part of self can include physical or structural loss in older adults and may include vision or hearing impairment. Furthermore, psychological loss can be associated with physical health challenges. According to Lin (2011), “communication impairments caused by hearing loss can lead to social isolation in older adults and epidemiologic and neuroanatomic studies have demonstrated associations between poor social networks and cognitive decline and dementia. The effect of hearing loss on cognitive load is suggested by studies demonstrating that under conditions where auditory perception is difficult (i.e., hearing loss), greater cognitive resources are dedicated to auditory perceptual processing to the detriment of other cognitive processes such as working memory” (p. 1134).
Furthermore, according to Cornwell and Waite (2009), research has found an association between mental health and social isolation. Loss of part of self also includes social role loss such as spouse role and worker economy role. Mrs. Brown was forced to retire because of her hearing impairment and she had limited social supports. She also lost the social roles of wife and employee. The aforementioned research findings would indicate that Mrs. Brown’s hearing impairment, physical mobility limitations, depression, mental health disorder, and retirement may be associated with her social isolation.

The loss of income, property, and photographs are examples of loss of external objects. This category may also include economic loss resulting from inflation and/or decrease in income through retirement (Simos, 2000). McCoyd and Walter (2016) emphasize the importance of the comfort and familiarity that the home environment provides for the elderly. The authors state, “regardless of the nature of the move, many older adults experience feelings of sadness and loss when giving up a familiar setting and many of their possessions” (p. 272). The move of Mr. and Mrs. Brown to the retirement community 25 miles from their previous home of 45 years illustrates the possible lack of comfort that Mrs. Brown might have experienced, especially in light of her introverted personality. The lack of engagement with other community residences may then lead to social isolation.

At age 70, Mrs. Brown would be in Erikson’s development stage of integrity versus despair. During this life stage, older adults face physical changes such as chronic illnesses, social losses such as losses of family and friends through death and relocation as well as psychological challenges such as a major or minor neurocognitive disorders. Based on her history, Mrs. Brown would most likely experience the negative pole of despair resulting in social isolation.

CONCLUSIONS

The case of Mary Brown illustrates the extent to which older adults may experience unresolved grief reactions in a combination of loss categories. These grief experiences can lead to social isolation. Simos (2000) indicates that there are also subtle losses that may go unnoticed and untreated. “If the loss itself is unnoticed, in all likelihood the reaction to the loss will also be misunderstood” (p. 19). As noted in the case of Mary Brown, there is no indication that she had been assessed for or received treatment for grief despite her long history of depression. Even when receiving treatment for her depression, the connections with loss caused by several geographic moves and lack of friendships may have gone undetected. Based on the case history, it could have been predicted that as an older adult, Mrs. Brown would become socially isolated.

Social isolation may lead to physical, psychological, social, relationship, and spiritual challenges for older adults. A systematic review conducted by Franck, Molyneux, and Parkinson (2016) found that reminiscence therapy, group-based activities that offer support and social integration, and story sharing were effective means of social integration and should be considered in the case of Mrs. Brown. Some other social integration techniques may include, but are not limited to, daily telephone contacts, group therapy, friendly visitors, development of formal and informal support networks, enrollment in senior wellness programs, and assistance in receiving hearing habilitation.

Loss experiences and unresolved grief reactions are important foci for social work intervention and should be considered as contributing factors in social isolation.

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REFERENCES


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