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Chapter Seven

Social Health: Beyond Absence of Social Isolation and Loneliness

Lihua Huang and Lisa Peterson

Case Studies 7.1

Sally is an 86- years old Caucasian widow living in a memory unit nursing home. She has been living with middle-stage Alzheimer's. She was moved into the memory unit two years ago when her children, Ron and Rick, decided that living alone in the rural countryside was no longer feasible after she had been found wandering more than half a mile from her home wearing a thin sundress on a snowy winter day.

Before Alzheimer's had set in Sally had been a homemaker for her family. A year before being placed in a nursing home, her husband Elijah passed away from a long battle with lung cancer. With no children at home and no husband to care for, Sally struggled to adjust to the solitude. Without her husband's support she struggled with simple tasks such knowing the date or her own phone number. After decades of cooking for her husband, her refrigerator was often full of individually plastic wrapped plates of food for Elijah. Rick and Ron made active efforts after their father died to visit with their children to keep Sally's spirits up, but as time progressed Sally became ornerier and more short-tempered with her grandchildren.

After two years in the unit, Sally had adjusted to her new home. She had enjoyed social events, especially her knitting circle and the ballroom dancing evenings. Ron and Rick visited twice a week each, often bringing pastries from her favorite bakery. When the COVID-19 pandemic hit the United States in March 2020, Sally's world became a lot smaller. Ron and Rick were not allowed to visit. The ballroom dancing evenings were cancelled indefinitely and knitting club was reduced to patterns and yarn being passed out to interested residents.

Sally's biggest frustration has been social distancing. She has always been physically affectionate and makes a point to give hugs to her favorite residents and staff. While she has been told why social distancing is important and there are reminders throughout the unit, she still

feels hurt whenever a staff member takes steps away from her. The disposable masks the staff wear cause Sally to have outbursts, shouting at staff members she had previously been able to identify, believing she was being sent to surgery. Despite her hesitation to use computers, a resident aide helped her video call each of her sons which improved her mood tremendously.

The longer the pandemic continued the worse her dementia symptoms have gotten. She began sleeping during the day, largely out of boredom and would spend hours at night reading the local newspaper cover to cover, worrying endlessly about those diagnosed with the virus. Resident aids began having to help her choose her clothing and assist in dressing her, as she started wearing her regular clothes on top of her pajamas. She stopped knitting altogether. When asked if she wanted to video call Ron and Rick, she stared blankly at the resident aide not recognizing her children's names. Her concerns over resident aides wearing masks grew increasingly challenging, as her shouting started to include flailing her arms and refusing to change her clothing.

Case Study 7.2

Alfred, 75, is an African American gay man who has lived alone in a small apartment for the past several years. Shortly after high school, his parents and friends began asking why he hadn't pursued any romantic partners. After a year of questions like this, he came out to his family. His parents were mortified by the news and after a month of attempting to talk him into conversion therapy to no avail, they severed ties with him. The separation of his family weighed heavily on him,

Alfred lost his job as a bank teller shortly after he had come out to his family. The word had spread in his close community and one day the store manager told him it was his last shift, with no further explanation. After months of scraping by, he found a job at a black owned suit shop a few towns over. The owner appreciated his careful eye and didn't ask any questions about his orientation. The position came with no benefits but paid the bills.

After a few years working at the suit shop, a confident and charismatic man walked into the store looking for a suit. The next week the man appeared again, but this time with a note and a phone number. The man, Reggie, introduced Alfred to the underground gay community in their town. For the first time in his life, he had found a space to belong. It wasn't long into dating before Reggie came down with what they thought was the flu. After a period of hospitalization, Reggie was diagnosed with HIV/AIDS. After a ten-month fight, Reggie passed away.

The loss of Reggie was painful for Alfred to process. Their relationship had barely started and was taken so quickly. After years of remaining single, Alfred dated occasionally, but nothing serious ever came from it. At 65, he retired from the suit shop and began collecting social security. The suit shop allowed him to meet his needs, but building a retirement account was never within reach.

Without the suit shop to occupy his time, Alfred had struggled with his sense of purpose. He had his routine to keep to but outside of grocery shopping and the occasional doctor's appointment, he could go for days without having any company over. George, one of his longtime friends within the gay community, invited him to the LGBTQ Senior Center for breakfast and a group meeting. Alfred had low expectations but agreed to join him. Much to Alfred's surprise, the $1.25 breakfast exceeded his expectations. The gay men's group following breakfast gave Alfred the feeling of community he hadn't felt since the 1970s. Some men had come with their long-term partners, some like him had come alone. The topic for the week was loneliness. Alfred found that many of the men in the group had the same struggles with tired routines and lack of social connection. After the meeting, Alfred thanked George for the invitation and agreed to start coming every Tuesday morning.

Case Study 7.3

Karol, 68, is a member of the Grand Traverse Band of Ottawa and Chippewa Indians and a lifelong environmental activist. Inspired by tribal elders, Karol has continued the advocacy work for native land and waterways. In recent years, she has been an organizer for Line 5 protests. Line 5 is a pipeline that runs crude oil through the straits of Mackinac. Indigenous people have been a leading voice in concerns regarding the oil spill threat Line 5 poses.

Karol spent her career as a high school English teacher at the local public school. She loved the opportunity to instill a love for reading in young people. Every fall she had students read banned books and encourage them to consider why the books may have been banned. Opening the minds of young people to think for themselves was a true passion. After retiring three years ago, her love for activism has blossomed.

Karol’s only daughter, Kim has always supported Karol’s advocacy work. Dozens of Kim’s childhood memories are of standing with her mother at protests. While Kim reluctantly attends many of the protests Karol has organized, she has never shown any indication that she would want to follow her mother’s legacy. Kim’s daughter, Katrina now 24, has enthusiastically expressed interest.

Katrina has eagerly participated in protests and advocacy work with her grandmother. The two have grown closer in the past few years as Katrina’s interest in Karol’s work has increased. Katrina has even expressed interest in participating in the Grand Traverse language classes to learn Anishinaabemowin, the native language of their tribe. This intergenerational relationship has been mutually beneficial for Karol and Katrina. Katrina is able to feel connected to her tribe and Karol is able to pass on the traditions and activism she has held dearly.

Social Health: Beyond Absence of Social Isolation and Loneliness

Humans are social beings. Sally's experience in the COVID-19 pandemic narrated in Case Study 7.1 has made this abundantly clear: Social contact and connection are basic human needs and rights, whether young or old. However, the needs and rights of older adults for human contact, social connection, and social inclusion have not always been recognized and respected, even by earliest attempts in social gerontology. Social gerontology is a field that studies social conditions and their impacts on the human aging process. In the 20th century social gerontology opened a door to a multidimensional understanding of aging because it introduced the social meaning of aging into gerontology and advocated to examine and document aging experience beyond biomedical diseases and psychological crises.

Since social gerontology first emerged in 1930s, it has evolved. It experiences challenges, growing pains, and opportunities. Clinical and macro social workers can learn from failed and survived early and ongoing theoretical attempts in social gerontology to make better sense of social changes in later life, social construction of social health, and ways to protect the rights of older adults to social health in later life.

Social Construction of Disengagement

Some of earliest attempts in social gerontology reflected the social construction of aging at the time. While they might capture the changing nature of social life of aging, these attempts centered attention to loss of social relationships, detachment, and age segregation, rather than social health. Disengagement theory and role theory are two examples that unexamined its ageist assumptions and rationalized age segregation and social exclusion in later life.

Disengagement Theory

The first disengagement theorists viewed disengagement as an adaptive behavior to aging and death (Cumming & Henry, 1961). However, disengagement theory might be the worst case of ageist propositions systematically proposed by early social theories of aging. As a theory, it can best be viewed as a retirement theory in a specific historical context. It might document and interpret post-retirement behavioral patterns of disengagement in some of white, middle class, and retired older men in the middle 20th century, when deliberated exclusion or internalized self-exclusion was viewed the dignified adaptive mechanism (Cumming & Henry, 1961). Although the disengagement theory was built upon a longitudinal study and it made efforts to include working women and people with different personality traits (Hooyman & Hiyak, 1988), it has limited generalizability for a couple of reasons. First, the theory could not be generalized to non-dominant groups of older adults who worked in a traditional workforce. Women's diverse aging experience and others who didn't the privilege to enjoy retirement were not represented in this theoretical perspective. Second, there has not been evidence supporting the premise of disengagement (Fry, 1992). Disengagement theory is also inapplicable for those living intergenerationally. Intergenerational living is much higher in Black, Indigenous and People of Color (BIPOC) families than that of the white majority (Baker et al, 2014). With higher rates of intergenerational living, closer family connections and interdependence within networks are integral to the aging experience. Disengaging is not an option.

Lack of generalizability is further magnified by the changed social profile of older adults in the 21st century. The theory fails to provide a viable framework to conceptualize the social realities of aging populations. The new social gerontologists and social work practitioners observe the growing numbers of older adults who demonstrate social engagement rather than disengagement. There are older workers who either must work due to financial reasons, just like

many older adults in history or have the privilege to choose to work at a different pace. There are students who decide to go to school or go back to school in later life. Moreover, the premise of disengagement theory was deeply rooted in intergenerational conflict rather than generational connection. It assumed that that all social systems needed to disengage with older people, as older adults must disengage with them, to transfer power from older adults to younger generations (Fry, 1992; Hooyman & Kiyak, 1988). Retirement policies, for instance, were assumed to be a way to ensure the younger people would move into occupational positions that the retirees made available. The concept of disengagement also fails to capture changes in the social relationships. Older adults might withdraw from one set of relationships, such as job-related relationships, but engage more with other relationships, such as family, friends, or communities. Total detachment from the external world is uncommon. Lastly, from a disengagement theory point of view, older adults should not seek formal or informal help. Professionals should encourage older adults' withdrawal even when health and human services are provided, rather than empower them to participate and make their own health decision (Hooyman & Kiyak, 1988).

Role Theory

Role theory is another early dominant social gerontological theory. It centers social aging on changes in a person's roles and relationships. While the tenets like "the individuals have a variety of culturally defined roles in the life course" and "roles are the basis of self-concept" were critical for the role theory, it was its third tenet that revealed its age-based nature: "Individuals' ability to perform in their role(s) is associated with a certain chronological age or stage of life" (Cottrell, 1942; Hooyan & Kiyak, 1988, pp. 63-64). In most traditional and modern societies, especially western societies like the United States, chronological age is used to assess

qualifications for socioeconomic and civic roles or activities such as those of Presential candidates, students, voters, drivers, or Medicare enrollers. The society and specifical social circles expect actors assigned to a given role behave with in certain boundaries. According to Cottrell, role theory can reduce adjustment anxiety in older adults and frustration in the society if there are explicit social norms and boundaries assigned to older adults and their social roles, based on their capacities. Age-based social norms not only script the roles expected of older adults, but also the way they are assigned to carry out these roles. For example, when an older widower starts dating and staying out late at night, his adult children might disapprove that he should "act his age." Age norms might be present as social policies and law. For example, the *Social Security* currently sets 62 as the early retirement age, and full retirement ages based on one's year of birth. The *Age Discrimination in Employment Act* of 1967 prohibits employment discrimination against persons 40 years of age or older. These examples reveal that socially accepted age norms could be unjust and devalue middle and older adults. They often have detrimental psychological consequences for older adults. Age norms function as social clocks. People use this social clock to map their life. For instance, white middle class men might have expectations about the appropriate age at which to graduate from school, start work, buy the first house, marry, have a family, reach the peak of their career, and retire.

Social norms are changing. Some older adults have broken out of the social clock of life transition timetables (Stanford Center on Longevity, 2022). As the World Health Organization (WHO) reframed aging via the Global Campaign to Combat Ageism and the Age-friendly Cities and Communities, the theoretical framework of social health of aging has moved from an age-based framework to an role-based framework (Ng & Indran, 2021). The role theory might have the opportunity to distinguish itself from its ageist origin because it was given a new life beyond

its original age-based tenet. This reborn social theory of aging is more inclusive and reflects social health needs and rights of older adults. While it might be more inspirational, older adults do have more social choices for their work life, education, intimate relationships, living arrangement, and social engagement than their previous generations. More older adults take on new roles beyond the role of a grandparent. Vidovićová (2018) listed six social roles of older adults: Active ager, the entrepreneur, the religious person, the volunteer, and caregivers, and the worker, as well as various intersections between them. Older adults have many more new roles than these six. They might also be a community organizer like Karol in Case Study 7.3, who advocates for environmental justice with her granddaughter Katrina. Older adults also can be a newlywed, a mentor, a voter, a reader, a singer, a roommate, and more. LGBTQ older adults who come out in their late adulthood might also have new sets of social roles.

However, older adults also often find themselves lacking appropriate role models. It is normal when they started work, there was a job orientation but when they retired, nobody can give them a retirement orientation. Human aging is a relatively new experience. Pipher (1999) calls aging another country where an unknown language is spoken, and the older adults must decode the language and learn to build a meaningful life in this new territory. It is a challenging, but it also presents opportunities to reengagement for older adults and the societies. For example, social connections and social networks fluctuate as social circles change and modify over time. Older adults often reengage with their changed social network by substituting lost roles with newfound roles, a distanced ones with new ones within the proximity. A newly downsized couple lost their long-time neighborhood and neighbors but may gain new neighbors and roles in the new neighborhood. Similarly, Sally in Case Study 7.1 joined the knitting circle and the ballroom dancing evenings at the nursing home after she moved there two years ago when she

lost husband to lung cancer and had conflict relationships with children and grandchildren. She was able to enjoy her adult children Ron and Rick's biweekly visits while making new friends in nursing home before COVID-19.

Social Construction of Relationship Changes

Early activity theory and continuity theory also recognized social changes and psychological adaptation in later life. However, they approached social changes differently from disengagement theory and role theory. The core difference is that these newer theories recognize negative ageist propositions disengagement and age-based social roles represented are detrimental to older adults' life satisfaction. Instead, activity theory and continuity theory built their frameworks on positive ageist propositions that demand productivity and continuity in later life. They stressed the benefits of continued social roles or adaptive mechanism from middle adulthood to facilitate older adults' sense of productivity and self-concept. Similar to disengagement theory and role theory, activity theory and continuity theory built their theoretical frameworks on white, middle class older adults and neglected older adults' human diversity.

Based on the longitudinal Kansas City Study, activity theory drew a correlation between social activities and life satisfaction (Havighurst, 1963, 1968; Hooyman & Kiyak, 1988). Activities were categorized as formal and informal activities, and social and physical activities. In Case Study 7.2, the breakfast and a group meeting on loneliness Alfred had in his first day at the LGBTQ senior center are semi-informal social activities. It is not unusual to connect recreation events and travel tours at retirement communities, and exercise classes at senior centers with activity theory. However, activities the Kansas City Study narrowly referred to were middle-age activities or work-related activities. In some ways, activity theory replaced activities for the roles in role theory and reinforced the societal values of productivity to older adults. It

attempted to generalize the desire to keep their same pattern of productivity or the same level of activities because positive self-concept could only come from work or productivity. In another word, older adults have no value if they do not work or carry out work related activities. There was only one way to achieve successful aging and it was keeping what the older adults always did. It is only nature that activity theory could be the foundation for policies such as delayed retirement ages. Early activity theory reached a peculiar theoretical proposition: Recognizing social needs of older adults without recognition of the importance of social health in aging experience.

Critics of activity theory have looked at other variables that predict life satisfaction, such lifelong experiences, SES, culture, generations, personality, and functioning or abilities. For example, it was evident that active older adults generally are better educated and have more resources and options than their less- active counterparts. However, with all the flaws in its premise, activity theory demonstrated its theoretical possibilities to further develop into a framework for social inclusion and social health in later life. For example, recent evidence connects physical activities and biopsychological health (Aghjayan et al., 2022; Dib et al., 2020). Group activities such as group exercise or group dance have positive impact on movement and social interaction for healthy older adults as well as older patients (Bungay, Hughes, Jacob, & Zhang, 2019; Choi et al., 2022).

Continuity theory was developed through a longitudinal study by Atchley (1999). Using social constructionist perspective, this theory suggested that older adults have the agency to actively participate in social contacts and lifestyles. It proposed that even though social relationships change in later life, older adults seek continuity and stability of one’s adaptive patterns to the changing environment by substituting new roles for lost ones (Atchley, 1989;

1999). Some of examples of adaptive patterns included personality, lifestyles, and preference. Among specific assumptions and propositions, Atchley claimed that the key proposition was "Continuity of general patterns of thought, behavior, and relationship is the first strategy people usually attempt to use to achieve their goals or adapt to changing circumstances" (Atchley, 1999, p. 101). The theory posited that the balance between change and continuity derives from older adults' self-identity formed over the life course. In other words, in responding to familiar or new external constructs, older adults become more of themselves. Their central personality characteristics become more pronounced, and their core values and behavioral patterns become more salient. According to continuity theory, continuity in internal constructs, lifestyles, and relationships not only facilitates older adult in maintaining social contacts and connections, but also benefits them in developing mature form of themselves and achieve ego integrity.

Continuity theory has the strengths that disengagement and activity theories are missing, especially in its emphasis on social needs and human agency of older adult. It was applied into theorization of many social phenomena in later life, such as retirement and bridge employment (von Bonsdorff, Shultz, Leskinen, & Tnsky, 2009), older adult friendships (Finchum & Weber, 2000), and dementia care (Menne, Kinney, & Morhardt, 2002). However, continuity theory primarily focuses on the individuals. It overlooks the environmental factors in aging. The implication of continuity theory for policy making will lead to an individualistic approach to solve any aging related issues and leave older adults who have less or no access and resources to "live or die." Its impact on historically oppressed older adults could be particularly alarming. Similarly, when continuity becomes a rigid rule, it might be detrimental for older adults' self-esteem, adjustment, and help-seeking if life events such as major illness, and financial or housing insecurity may require modifications in one's typical lifestyle or coping mechanism.

Looking at early dominant social gerontology through the intersection of ageism, racism, and social health rights of older adults, it is both disturbing and helpful to witness the magnitude of racism and professional ageism. Social health theories have often been presented through the lens of the white majority. In Black, Indigenous and People of Color (BIPOC) communities, aging experiences, values, and relationships vary dramatically. Continuity theory missed the mark when considering individuals who may be leaving work to take on other roles – such as caretaker for grandchildren. Volunteerism has a special place in activity theory. However, research regarding the impacts of volunteerism in aging populations is often done through the lens of white savior volunteerism. Within Latinx and African Americans these informal volunteer roles often do not register as a form of volunteerism, but rather as a core element of life. Informal volunteering through supporting neighbors and volunteering within church communities are often not considered when analyzing volunteer rates (Johnson & Lee, 2017; Baker et al., 2014). Case Study 7.3 also illustrates how volunteerism looks different among BIPOC communities. Karol engages with her community and the large society as an environmental activist and cultural educator, not a typical school classroom or nature conservation center volunteer. Meanwhile, transportation and health issues, and lack of free time, which are higher among all minority groups, are barriers to traditional volunteerism (Johnson & Lee, 2017).

Although social gerontology has well documented the theoretical and methodological flaws and deprivation in earlier social theories of aging, their influence is more than present. For instance, while disengagement theory has been mostly debunked, one could find the direct link between its disengagement proposition and age-restricted private retirement communities and policies protecting such a discriminatory housing practice. From the first retirement community

in 1923 to a growing retirement community industry, the only continuity of this century-long housing model is disengagement or age-segregation, even though it has evolved into different shapes with different names, such as continuing care retirement communities (CCRC), retirement villages or lifestyle villages, and naturally occurring retirement communities (NORC). Retirement communities have a nickname "55+ Communities," which legitimatize spatial segregation of the older adults from younger generations (Bauer 2013; Papke, 2021). The laws enable such age-segregation social systems are the *Fair Housing Amendments Act* (FHAA) of 1988 and the *Housing for Older Americans Act* of 1995. They allow a community or village to be age-restricted to those age 55 and over when the housing is intended and operated for residents in this age group, and at least 80% of the units are occupied by at least one person who is 55 years of age or older.

Social Construction of Social Health

Ageist interpretation of older adults' social relationships with the society and their own aging process, along with social policies and social infrastructures built upon ageism, has denied older adults' needs and rights to contact, connect, and engage social life, thereby, also excluded them from social spaces that nourish older adults and enrich the society. The consequences of social exclusion and social disengagement are dire for both the society and the older adults. These consequences can consist of age-segregated communities and cities, social isolation, loneliness, shortened life expectancy, biopsychological disorders, food and housing insecurity, poverty, generational inequality and inequity in resources and access, toxic generational relations, and more. Social gerontology in the 21st century has the opportunity to learn about the social rights and needs of older adults and to promote and protect their social health and that of socity.

The notion of *social health* dates back to 1948, if not earlier. The Constitution of the WHO in 1948 defined social health as "a state of complete … social well-being and not merely the absence of disease or infirmity," and as "basic to the happiness, harmonious relations and security of all peoples" (WHO, 1948, p.1). However, compared to physical and mental health, social health is the least familiar term in healthcare. To lay down a foundation for analysis and promotion of social health in older adults, we propose an operational definition of social health, building on the WHO definition and social gerontology traditions: Social health is a state where social integration and autonomy are best balanced for the older adult based on their personality, physical conditions, mental capacity, or their individual and collective identity at a specific time. In the state of social health, the older adult is most satisfied with their connections with the external social contacts and relationships as well as with their internal self. This state is not merely absence of social health disease such as exclusion, social isolation, or loneliness. We classify social exclusion, social isolation, and loneliness as social health diseases because they demonstrate types of social conditions that negatively affect an older adult and their society's social structure and function of this individual or associated society.

Social Isolation and Loneliness

It is noticeable that the literature on social health of aging has overwhelmingly focused on two social health diseases: social isolation and loneliness of older adults. While social isolation and loneliness have overlaps and are often used interchangeably (Nicholson, 2012; White, Taylor, & Cooper, 2020), they are two distinct social conditions. Social isolation can be defined as an objective social condition where there is lack of social contact or interaction with others or social support (NAP, 2021; Shiovit-Ezra, Shemesh, & McDonnell, 2018). On the other hand, loneliness is a subjective feeling of being isolated, lack or loss of social connectedness, or

inadequate social connections and relationships, independent from the size of social networks (NAP, 2021; Shiovitz-Ezra et al., 2018). Some also call loneliness "subjective social isolation" (Cole et al., 2007). Shiovitz-Ezra et al. (2018) empathized the cognitive discrepancy between objective deficits of social connection and feelings of loneliness. An older adult might experience social isolation or loneliness, or both. Previous to COVID-19, the Administration for Community Living's Administration on Aging of the U.S. Department of Health and Human Services reported about 28 percent of older adults in the United States, or 13.8 million people, live alone, but many of them are neither lonely nor socially isolated. At the same time, some people feel lonely despite being surrounded by family and friends (ACL, 2018). Alfred in Case Study 7.2 is a good example. He experienced many losses in his life. He lost family of origin to homophobia, then lost Reggie to HIV/AIDS. Other than the gay community, he mostly lived solitarily, and felt lonely. When he joined the men's group at the LGBTQ Senior Center, he felt connected with these men who shared the same social struggles. He was living alone but no longer aging alone, and he was no longer lonely (ACL, 2018; Djundeva, Dykstra, & Fokkema, 2019).

Social isolation is viewed as a state in which individual has a minimal number of social contacts, interactions, connections, and relationships with family, friends, neighbors, or other people from one's social circles (Berg & Cassells, 1992). While neighbors are spatially close by, family and friends can be nearby or physically distant. Social isolation may or may not lead to loneliness. There are several well-known instruments assessing social isolation or social networks. Gerontological social work studies widely use different versions of the Lubben Social Network Scale to assess the number of social contacts with family members and friends. The Lubben Social Networks Scale-18, 12, and 6 (LSNS-18, LSNS-12, and LSNS-6) are correlated

with mortality, hospitalization, depressive symptoms, and overall physical health (Lubben, 1988; Lubben et al., 2006).

Cognitively, those experiencing social isolation in later life are at a greater risk developing not only loneliness, but also dementia and ultimately Alzheimer's Disease. Grande et al. (2018) followed 345 participants over the course of three years. They found that individuals living alone with mild cognitive impairment had a diagnosis of dementia a year earlier than their counterparts who lived with someone, and that living alone was associated with a 50% increase in dementia. Although it was a necessary COVID-19 protection measure, the absolute social isolation created by "social distancing" elevated the Alzheimer's progress in Case Study 7.1. Sally was cut off from physical contacts with her sons and staff members, then she lost motivation to dress and interest in her favorite activities like knitting. She even could not recognize her sons' names.

Loneliness is named as a killer (Cole et al., 2007; Shiovitz-Ezra et al., 2018; White, Taylor, & Cooper, 2020). Among loneliness assessment instruments developed by social gerontologists in the 20th century, the widest employed instrument is the 20- item UCLA Loneliness Scale which was first released in 1978. It intends to assess one's subjective feelings of loneliness and feelings of subjective social isolation (Russell, 1996). It resulted in documented evidence of loneliness and its impacts on mental and physical health, based on self-reported loneliness. It has been used for psychosocial and biomedical research on social health. For example, gerontological social work scholars Schiovitz-Ezra and Parag (2019) documented that loneliness could increase systolic blood pressure and worsen cardiovascular health, and there were correlations with lung disease, arthritis, and peripheral vascular disease as well (Schiovitz-Ezra & Parag, 2019).

Recently biomedical researchers discovered biomedical expression of loneliness. Studies have found that loneliness leaves people more likely to die from heart disease and is a contributing factor in other fatal conditions. For example, Cole et al. (2007) identified loneliness in older adults' white blood cells. They found that chronic loneliness expressed itself in inflammatory and immune response genes because the body sensed the threat and activated pro-inflammation pathways that weakened the immune system. It creates an environment for the development of atherosclerosis, heart attacks, neurodegenerative diseases like Alzheimer's disease and metastatic cancers (Cole et al., 2007). In 2018 Cole explained that loneliness is more dangerous to health than obesity, and that it is the equivalent of smoking 15 cigarettes a day (as cited in Gandel, 2018).

Studies continue to show that the negative health effects of loneliness and isolation are especially harmful for older adults (Darling, 2019). However, the impacts of social isolation and loneliness go beyond individuals and their families. An AARP 2017 study (Flowers et al., 2017) reported that Medicare spent almost $6.7 billion a year on socially isolated older adults from 2006 to 2012, mostly because of longer hospital stays - a result, researchers hypothesized, of not having support at home (Darling, 2019).

Social Connectedness

The operational definition of social health in aging integrates the theoretical rationale of person-in-environment theory, social determinants of health, and intersectionality theory. It explains that social health in later life results from both personal agency and institutional design. Thus, social health is multidimensional. It consists of institutional social inclusion and personal social connectedness in the social context in which the older adult partakes. However, the disease- focus social health approach also reveals an unbearable concentration on the individual

dimension of social health. This individualistic orientation demonstrates in the literatures on older adults' social isolation and loneliness as well as on their social connectedness (Mendes de Leon, Glass, & Berkman, 2003; Lubben, 1988), even though the literature long has attempted to capture multidimensional nature of social connectedness of older adults.

One effort can be marked by the number of instruments seeking to measure social connectedness in older adults. The first set of instruments is two social network measures: the Berkman-Syme Social Network Index (BSNI) and the Lubben Social Network Scale (LSNS). Social networks in these instruments is a quantifiable term for the total quantity and quality of social connections. They intend to measure the structure, the content, and the function of the social relationships. The structure refers to the existence and quantity of social contacts and connections. It comprises the size, composition, frequency, density, strength, availability, and directions of the relationships. The content refers to subjects exchanged between the older adult and their network members. These subjects can be information such as COVID-19 vaccine for Sally's nursing home or the senior center eligibility for Alfred, values such as the Chippewa Indian's belief in decision-making in the eye to the seventh generation that Katrina learned from Karol, and behaviors such as attending a book club or activism. The function of social networks often implies support, conflict, and control. More specifically, support networks provide emotional, instrumental, informational, appraisal support.

Although the BSNI and the LSNS each has a distinct focus, both include multidimension of social connectedness that older adults with their interaction with individuals, families, neighborhood/communities, and organization. The LSNS measures the structure and the content of interpersonal networks, such as the network size, composition, strength of ties, reciprocity, and change in networks over time with their family members, friends, and neighbors (Lubben,

1988). The BSNI measures the function of relationships between older adults and their intimate partner, relatives, friends, neighbors, and members from communities such as religious or spiritual organizations and community organizations, containing both interpersonal relations and group membership (Berkman & Syme,1979). They conceptualize social connectedness as the combination of the quantity and quality of social relationships and connections (Berkman & Syme in 1979; Lubben, 1988). The bigger the social networks and the more connected the older adult feels, the better is their social health. A cautionary tale on the social network literature is the shadow of the disease orientation, which turns the focus of social connectedness to social isolation and loneliness, rather than social connectedness in older adults (Steinman et al., 2021).

Other efforts have been made to assess the functional dimension of social networks in older adults. Social support increases quality of life, buffers depression, increases healthcare service use, and even influences clinical outcomes among older adults (Chamers et al., 2022; George, Blazer, Hughes, & Fowler, 1989). It inevitably draws multidisciplinary and multi-professional attention. Two well-known instruments assessing functional social support are the Duke Social Support Index (DSSI) and the MOS Social Support Survey (MOS SSS). The DSSI constructs subjective social support through five support indices: satisfaction with social support, perceived social support, frequency of social interaction, size of the social network, and instrumental support (Landerman, George, Campbell, & Blazer, 1989). The MOS SSS was initially developed in the Medical Outcomes Study (MOS) for a large sample of patients aged 18-98 with chronic conditions (Sherbourne & Stewart, 1991). It consists of all four dimensions of functional support: emotional, instrumental, informational, and appraisal support.

Another attempt to break through the individual orientation in investigation of social connectedness is a new attention to social integration, social participation, and social engagement

in aging experience. The major challenge of this movement falls on conceptualization of social connectedness. For example, when de Leon, Glass, and Berkman (2003; Glass, de Leon, Bassuk, & Berkman, 2006) analyzed data from the Established Populations for Epidemiologic Studies of the Elderly (EPESE), social engagement was constructed as participation of 11 social and productive activities, from a pure activity theory lens. Some of activities, such as fitness activity and meal preparation, were not necessarily social. Although, almost twenty years after the publication of the EPESE study, social engagement can still be used as an empty shell to describe some properties different from social isolation and loneliness, the effort has continued. For instance, recently, Mackenzie and Abdulrazaq (2021) differentiated social (activity) participation from social engagement. They operationalized social participation as number of activities, time spent in them, and volunteerism; and social engagement as the number of friends and family they see, feel close to, and can discuss personal matter with. In other words, social participation and social engagement operate as forms of social networks.

This stagnation in approaching building blocks of social connectedness in aging might cause frustration, especially because Berkman, Glass, Brissettee, and Seeman (2000) had established a bridge between social networks and social integration through the framework of Durkheim's social integration in which the social-structural conditions such as culture and socioeconomic factors, policies, and social change shape the extent and nature of the social networks. Scholars in social engagement of older adults are keenly aware of this study but unfortunately passed by the central premise of Durkheim's framework for macro conditions of social networks, and went directly back to social activity participation (Rosso, Taylor, Tabb, & Michael, 2013). Other lessons social gerontologists and social workers can learn from Berkman et al. (2000) is the inclusion of proximity and homogeneity in the social network structure and

nonvisual contact, the differentiation between face-to-face contact and nonvisual contact, and psychosocial mechanisms such as social support, social influence, social engagement, and access to resources (p. 847). For example, information about intergenerational contacts and their size, frequency, strength, reciprocity, and influence would enhance our understanding and working toward mutually social connectedness of older adults and the society greatly.

Social Determinants of Social Health

We cannot avoid social determinants of health if we expect to comprehend and explain and enhance social health of older adults. Although social work has long held the person-in-environment perspective in understanding human conditions, behaviors, and relationships, the notion of *social determinants of health* is the conceptual framework WHO proposed and articulated. This framework addresses context of health, structural determinants of health, and intermediary determinants of health (WHO, 2010). A short definition quoted often is the Health People 2030 version: "Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Health People 2030, n.d.).

The theory of social determinants of health facilitates our understanding and vision of social health in later life. Among risk and protective factors contributing to social health of older adults, individual biopsychological factors such as health conditions and functioning, personality, temperament, lifestyle, history, trauma, agency, and resilience can influence or determine their structure of social networks and sense of social connectedness (Cumming, 1963; Havighurst, 1968). However, social health in aging is not a one-person show. It takes the older adult and their entire social environment, from their family, friends, and neighbors to the socioeconomic and political context, social services and health systems, and community and city

planning. At the individual level, race/ethnicity, gender, age, class, gender identity and sexual orientation, ability, immigration status, language, income, education attainment, retirement, health insurance plan, housing, etc. will impact the social health status of older adults. For example, a survey completed by AARP (2010) found nominal differences between ethnicities and loneliness. Burnette (1999) found that Latino older adults tend to have larger families, stronger bonds and more interaction and support from their adult children, and that those who did not volunteer or belong to a religious organization reported significantly higher rates of loneliness. The aging LBTQ+ community tends to have higher rates of loneliness when compared to their heteronormative counterparts (Kuyper & Fokkema, 2009). For instance, Alfred's support system was small due to decades of prejudicial beliefs and family separation.

At the society level, hidden risk factors disproportionally threaten minority older adults, older adults living in low-income or poverty, older adults with disabilities, and particularly older adults experiencing multiple social exclusion. For example, Housing policies, such as the *Fair Housing Amendments Act* (FHAA) of 1988 and the *Housing for Older Americans Act* of 1995, and public housing programs for older adults living in poverty reinforce generational segregation which further excludes older adults participating in society across life domains. Another example is the unique social conditions threatening social well-being of the older adults. The largest generation of millennials entering the housing market, soaring housing price, and inflation have contributed to homelessness in some older adults, forcing them leaving their neighborhood and friends, a risk factor of social exclusion, social isolation, and loneliness. Older lesbians in rural areas with higher poverty rates are more likely to receive no formal services. It is observed that poverty has posed unique challenges in many areas of rural older adults' life, such as social

isolation, housing affordability and availability, formal human and health service use, and disease management and prevention.

On the other hand, with renewed understanding of social determinants of health, new discoveries in gerontology and geriatrics, and technological advancement, social gerontology has a great opportunity to learn from older adults and rewire the society to build an inclusive, equitable, and meaningful future for all generations. The Age-friendly Cities/Communities Movement represents one of positive developments in this reconstruction. This most holistic effort aims to provide a social environment in which older adults could have the social infrastructure to live in an intergenerational community, participate social/civic/financial activities, enjoy outdoor spaces, have an age friendly built environment, and have access to transportation, healthcare, and technology. In this purposefully designed community/city, older adults can be respected as a fellow citizen. Their rights and needs of social health can be recognized and protected. They will have diverse social networks and feel connected. They can achieve a state of social well-being and complete harmony with the environment and themselves.

Chapter Summary

Social rights and needs of older adults are fundamental to optimal health in later life. While early social theories of aging provided theoretical concepts, the ageist values and white domination implicit in these theories have come to be seen as a form of social exclusion and harmful to the social health of older adults. We examine social health as a state of complete social well-being and two social health diseases: social isolation and loneliness. Using human rights, social determinations of health, and intersectionality, we propose a holistic approach of social health that requires both human agency and inclusive social infrastructure and public policy.

Chapter Review Questions:

1. What are the three "places" Ray Oldenburg's theory references?

    A. Home, Outside, Pubs

    B. Home, Work, Informal Gathering Spaces

    C. Indoors, Outdoors, Work

    D. Work, School, Informal Gathering Spaces

3. Explain the differences between disengagement theory and activity theory. Do they both seem relevant?

4. Give three causes of social role change as individuals age. Are any of them avoidable? Why or why not?

5. What are some potential long-term impacts of involuntary social isolation in aging populations?

Classroom Activities

1. Discuss with small groups the barriers you would likely have if you chose to continue living in your current home as you aged. Would the benefits outweigh the cons? Why or why not?
2. Make a list of third places you currently visit. How do they benefit your social health? How often do you visit them? What happens when you go for long periods of time without access to them?
3. Design a senior center event. What would the event focus on? Who do you think would benefit?
4. In a group of 5, make a conceptual map of social health.

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