12-2022

Chapter 7: Social Health: Beyond Absence of Social Isolation and Loneliness

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Case Study 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. As illustrated in Case Study 7.1, social distancing exacerbated Sally's and other older adults' social isolation during the height of COVID-19 in 2020. Sally's mood change and worsened Alzheimer's disease could be directly tied to the sudden and extreme social condition where she was forced to cut physical contacts with her social support system, including her adult children and nursing home staff, to protect her from the deadly virus. Stories like Sally's have made this abundantly clear: Social contact and connection are basic human needs and rights for dignity, quality of life, and optimal well-being, whether young or old. Deficit in social contact and connection can have negative impacts on older adults' physical, psychological, cognitive health, and overall quality of life.

The social health needs and rights of older adults have not always been understood, recognized, and respected, even though the notion of *social health* dates 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, social gerontology traditions, and salutogenesis (Mittelmark et al., 2017): Social health is a state where social inclusion and individual autonomy are best balanced for the older adult based on their personality, physical conditions, mental capacity, or their individual and collective identities 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 the absence of social health disease such as social exclusion, social isolation, or loneliness. It is promoted and protected by intentions of both the older adult and the political, economic, and sociocultural arrangements. We classify social exclusion, social isolation, and loneliness as social health diseases because they demonstrate types of social conditions for two reasons: They are closely related to discriminative social arrangements, and they negatively affect older adults and the society, in terms of social structure and function (Phillipson & Baars, 2007). Literature on social health in aging is scarce beyond social isolation and loneliness. In this chapter, we intent to examine social health as a status where social connectedness and social inclusion meet, and social exclusion, social isolation, and loneliness in later life are prevented.

Social Isolation and Loneliness

It is noticeable that the literature on social health of aging has overwhelmingly focused on two social health diseases that centered on individual older adults' social conditions: social isolation and loneliness. 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). It can directly refer to the size of social networks of the older adult. On the other hand, loneliness is a subjective feeling of being isolated, lack or loss of social connection, 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. The Administration for Community Living's

Administration on Aging of the U.S. Department of Health and Human Services reported that in 2018 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. Meantime, 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, lost Reggie to HIV/AIDS, and lost employment-based social connections. Beside 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 his 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

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. They each contribute to social relationships and social connectedness in older adults. There are several well-known instruments helping social workers assess social isolation or social connectedness. Gerontological social work studies widely use different versions of the Lubben Social Network Scale (LSNS) to assess the number of social contacts with family members and friends. The literature indicates that the assessment results of 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), and that they can be instrumental to understand the social health of older adults (Huang, 2011).

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 (Tyrell & Williams, 2020). Sally was cut off from physical contacts with her sons and staff members, then she lost interest in her favorite activities like knitting. She even could not recognize her sons' names.

Loneliness

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 most widely 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 has resulted 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 have 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 have discovered biomedical expression of loneliness. Studies found that loneliness leaves people more likely to die from heart disease and is a

contributing factor in other fatal conditions. Cole et al. (2007) identified loneliness in older adults' white blood cells. They found that chronic loneliness expresses itself in inflammatory and immune response genes because the body senses the threat and activates pro-inflammation pathways that weakens the immune system. It creates an environment for the development of atherosclerosis, heart attack, neurodegenerative diseases like Alzheimer's disease, and metastatic cancers (Cole et al., 2007). Cole later explained that loneliness is more dangerous to health than obesity, and that it is the equivalent of smoking 15 cigarettes daily (as cited in Gandel, 2018).

Studies continue to show that the negative health effects of loneliness and isolation are not only especially harmful for older adults (Darling, 2019). 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). The financial implications of loneliness and isolation in older adults for the greater society are examples how social health conditions in aging are deeply intertwined with the older adults' social environments.

Social Exclusion

We cannot fully understand and promote social health in aging without examining social exclusion and its influence on social isolation and loneliness. Social exclusion is defined as a socially constructed condition in environments where "individuals are unable to participate fully in economic, social, political and cultural life, as well as the process leading to and sustaining such a state" (UN, 2016, p. 18). It has long recognized that the dominant adults historically exclude and eliminate older adults and other disadvantaged members for the optimal functioning of the society (de Beauvoir, 1970; Fry, 1992). Ample contemporary evidence shows that social

exclusion can precipitate biomedical, mental, or social conditions such as cardiological diseases, depression, suicide, poverty, civic exclusion, or loneliness (Berkman et al., 2000; Nilsen, Celestem Lennartsson, McKee, & Dahlberg, 2022; Shiovitz-Ezra et al, 2018; UN, 2016). The United Nations' 2016 *Report on the World Social Situation*, for example, highlighted the vicious cycle between poverty, income inequality, and social exclusion. Meanwhile, evidence suggests that social exclusion contributes to both social isolation and loneliness. Shiovitz-Ezra et al. (2018) proposed a model where social rejection, stereotype embodiment, and social exclusion are pathways from ageism to loneliness.

The scope of social exclusion in aging makes it difficult to measure. However, it is acknowledged that four interconnected domains of social exclusion undeniably prevent older Americans from achieving optimal social health: Age segregation, unequal access to resources, unequal participation, and denial of opportunities (Bauer, 2013; UN, 2016). These social exclusion domains involve older adults' physical/spatial presence and engagement, as well as their political, socioeconomical, and technological participation. They provide us multidimensional access to understanding social exclusion in older adults. Even though the most researched social exclusion has been healthcare and labor market, especially mandatory retirement (Shiovitz-Ezra et al., 2018), there are numerous examples illustrating that older adults are not beneficials of public health literacy, housing, and information technology advancements (Bauer, 2013; Kleykamp & Kulak, 2023; Mace, Mattos, & Vranceanu, 2022). For instance, while public health campaigns have reduced cigarette use to the lowest recorded levels, older smokers have less access to tobacco control policies and knowledge of questlines or other local smoking cessation services (Kleykamp & Kulak, 2023).

Age Segregation

We define age-segregation as a mechanism through which the society organized by chronological age. While the trends of age segregation in the United States are debatable, there is a consensus that the age segregation between youth and older adults is the highest among all age groups (Wong & Das Gupta, 2023). This segregation is coincident with the fact that nuclear households continue overwhelmingly dominating American family and social lives, even when three-generation households are growing (Brown, 1979; Pilkauskas, Amorim, & Dunifon, 2020). Although age-segregation has been widely practiced in different systems such as education, public space, and criminal justice systems, age segregation in housing has been understudied.

Older adults have been spatially separated from the larger society by ageist housing practices, particularly by the design and legislation of retirement communities, nursing homes, and public housing. From the first retirement community in 1923 to a growing retirement community industry, 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). The only continuity of this century-long housing model is age-segregation or social exclusion. Retirement communities or "55+ Communities" legitimatize spatial segregation of the older adults from younger generations (Bauer 2013; Papke, 2021). The laws which 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.

There were reported an estimated 1.08 million older Americans living in nursing homes in 2018 and about 0.3 million older adults living in public housing facilitates in 2021 (NCHS,

2022, p. 21; Fiol, Gerken, & Popkin, 2022). As private retirement communities, nursing homes, public housing for older adults living with low incomes structurally exclude older adults from people who are not their age (Bauer 2013; Brown, 1979; Papke, 2021). Although nursing homes provide services to patients with high assistance needs for activities of daily living, older adults are disproportionally represented in nursing homes in terms of the percentages and the length of residence. Medicare mandates for social work services might have provide a lifeline for social health. However, public policies such as Medicare and Medicaid are the main drivers for the blooming private nursing home industry, which puts profits above health of older adults (Papke, 2021). It is reported that private nursing homes constitute 70% of nursing homes in the United States in 2018, compared with 23.2% nonprofit and 6.8% government and other nursing homes in the same year (NCHS, 2022, p. 9). Like nursing homes, particularly private nursing homes, public housing for older adults living with low income or poverty excludes older adults from the general population and exacerbate the biopsychosocial risk factors (Brown, 1979; Papke, 2021). Unlike nursing homes and private retirement communities, public housing for older adults living with both poverty and medical conditions has the double exclusion based on age and class. Housing policies, particularly the *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.

Age-segregation creates fundamentally "spatial and social barriers that exacerbate the risk of social exclusion" (UN, 2023, p. 87). Age-segregated housing devalues older adults and spatially blocks older adults from the rest of the society. These types of social exclusion are structurally harmful for both older adults and the society. The detrimental consequences include alienation and confinement of older and other generations, ageism against older adults and

internalized ageism, loss of access to socialization for both younger and older generations who each has unique knowledge and values about collective and personal development, discontinuity of history and culture, and the sense of loneliness and abandonment, along with fear of aging and death. A recent study reported that the age-segregated nursing home residence leads to a 41-month loss of life expectancy (Brent, 2021). Evidence from intergenerational learning programs also indicates that spatial and socially structural barriers have made young and older generations see less value of each other personally, and created fear of aging (Andreoletti & Howard, 2018; Kalisch, Coughlin, Ballardm, & Lamson, 2013; Krout et al., 2010).

Digital Exclusion

For good or bad, digital technologies provide new platforms for social connections. When it works, it reduces social isolation and loneliness. However, digital inequity in access and utilization might also intensify social exclusion and health disparities. For older adults, particularly historically oppressed older adults, the consistent and increasing digital inequity exacerbates unequal access, unequal participation, and denial of equal opportunities in this digital age. The COVID-19 pandemic further highlighted the nature of digital exclusion and its implications for social health of older adults.

Digital technology played a positive and transformative role in sustaining access to basic food, medication, healthcare providers, and social connections during the COVID-19 crisis. The literature has documented the adoption and the benefits of digital social connections and curative telehealth services for older Americans (Baudier, Kondrateva, Ammi, Chang, & Schavone, 2022; Doraiswamy, Jithesh, Mamtani, Abraham, & Cheema, 2021; Goldberg et al., 2021). The benefits range from better stress-management, lower levels of loneliness and fewer depressive symptoms, safety of medical and mental health care, reduction of barriers to care, maintenance of patient-

provider communication, disease self-management promotion, and cost-effect (Nimrod, 2020; Rennoch, Schlomann, & Zank, 2023; Mace, Mattos, & Vranceanu, 2022). The Center for Disease Control and Prevention (CDC) reported that in 2021, 37% of adults aged 18 and over used telemedicine in the past 12 months, and that this number was 43.3% in older adults aged 65 and over, ranked the highest age group among all adult age groups (Lucas & Villarroel, 2022).

Acceptance and usage of telehealth could be one of the biggest stories demonstrating that capacity for plasticity equally applies into later adulthood, that older adults can take advantage of telehealth and are using telehealth services, and that the pandemic has led to a newly developed digital infrastructure or environment in which equitable telehealth and digital technology assisted social connections may become possible alternatives. However, a closer examination of telehealth usage by Karimi et al. (2022) indicates that older American telehealth users have inequitable access to and participation in digital infrastructure transformation. More specifically, existing evidence suggests that the video-enabled telehealth service modality offers advantages over audio-only telehealth service modality in many clinical settings, and that older adults have lower access to this modality. Karimi et al. (2022) documented significant differences in video-enabled telehealth rates between older adults aged 65 and over (43.5%) and young adults aged 18 and 24 (72.5%) in the Census Bureau's Household Pulse Survey (HPS) data. A reasonable explanation is while enhanced Medicare reimbursement and COVID-19 induced expansion of telehealth services created an environment where older adults have a greater access to telehealth, inequitable access to telehealth persists for older adults, including access to the video-enabled telehealth and associated technology such as device ownership, broadband, or digital literacy.

Social Construction of Social Exclusion

As an ageist expression social exclusion manifests itself in public policies, free market, human and health services, and digital technology. It also manifests in social gerontology. Social gerontology is a field that studies social conditions and their impacts on the human aging process. When it first emerged in 1930s social gerontology opened a door to a multidimensional understanding of aging by introducing the social meaning of aging into gerontology. It also advocated for the examination and documentation of aging experience beyond biomedical diseases and psychological crises. However, some of its early attempts illustrated how the society constructed ageism and the social exclusion of the time. While these attempts might have captured the changing social life of aging, they centered attention to loss of social relationships, detachment, and age segregation, rather than social health. Two early and widely hold social theories have constructed, legitimated and reinforced social exclusion in aging experience.

Disengagement Theory

Disengagement theorists viewed intentional exclusion or internalized self-exclusion as an adaptive behavior to aging and death (Cumming & Henry, 1961). As a theory, it can best be viewed as a retirement theory in a specific historical context. It documented and interpreted post-retirement behavioral patterns of disengagement in some of white, middle class, and retired older men in the middle of the 20th century. Although the disengagement theory was built upon a longitudinal study and efforts were made to include working women and people with different personality traits (Hooyman & Hiyak, 1988), it could not be generalized to non-dominant groups of older adults who worked in a traditional workforce. Disengagement theory's lack of generalizability is further magnified by the changed social profile of older adults in the 21st century. 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.

Disengagement theory is also inapplicable for those living intergenerationally and having closer family connections and interdependence within networks (Baker et al, 2014). 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 vacated. The concept of disengagement also fails to capture changes in 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.

Role Theory

Role theory centers social aging on changes in a person's roles and relationships. While 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, the third tenet uttered 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 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, drivers, or Medicare enrollers. The society and specific social circles expect individuals 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 script not only 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 complain that he didn't "act his age." Age norms might be present as social policies and law. For example, 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 exclude middle and older adults from social activities. 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. Older Americans in general 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 grandparent. They might 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 singer, a roommate, and more. LGBTQ older adults who come out in their late adulthood might also experience new sets of social roles.

Although social gerontology has well documented the theoretical and methodological flaws and deprivation in earlier social theories of aging, it is crucial to consistently examine the influence of ageist construction of these social theories in policies and practices. For instance, , one could find the direct link between its disengagement proposition and age-restricted private retirement communities and policies protecting such a discriminatory housing practice. 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 excluded them from social spaces that nourish older adults and enrich the society. The consequences of social exclusion and social disengagement 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 an opportunity to learn about the social rights and needs of older adults and to promote and protect the optimal health of older adults and wellbeing of society.

Social Health

The operational definition of social health in aging proposed in this chapter integrates the theoretical rationale of person-in-environment theory, social determinants of health, and critical gerontology. It explains that social health is multidimensional, and that social health in later life results from both personal trials, agency, capacity, and identities, and institutional design. It also attempts to provide constructive and preventive solutions to social health diseases and explore

pathways to promote the social health of older adults. In this approach, social health consists of institutional social inclusion and personal social connectedness in the social context in which the older adult partakes. This premise departs from the contradiction in existing social health approaches. On the one hand, the literature has disease-focused and individualistic oriented which are two barriers for older adults to fully actualize the essence of social health (Mendes de Leon, Glass, & Berkman, 2003; Lubben, 1988). On the other hand, the literature long has attempted to go beyond social isolation and loneliness and decode social health in aging and its multidimensional nature ((Berkman & Syme in 1979; Steinman et al., 2021). To bring the focus back to social health rather than absence of social isolation and loneliness in aging, we have to learn more about the roles of objective and subjective personal social connectedness and institutional-level social integration in social health.

Social Connectedness

Early activity theory and continuity theory made efforts to interpret personal social connectedness in aging. Different from disengagement theory and role theory, they built their frameworks on positive ageist propositions that demand productivity and continuity in later life. They stressed social needs of older adults and the benefits of continued social roles or other psychosocial adaptive mechanism from middle adulthood to facilitate older adults' sense of productivity and self-concept.

Social Activities

Activity theory correlates social activities and life satisfaction, based on the longitudinal Kansas City Study (Havighurst, 1963, 1968). Activities are categorized as formal and informal, and social and physical. In Case Study 7.2, on his first day at the LGBTQ senior center Alfred engaged semi-informal social activities, namely the breakfast and a group meeting on loneliness.

Programs in senior centers and retirement communities often follow the premise of activity theory to provide social connections through recreation events, travel tours, and exercise classes. The critics of activity theory draw attention to its positive ageist stereotypes. In some ways, activity theory replaces activities for the roles in role theory and reinforces the societal values of productivity to older adults. It attempts to generalize the desire to keep their same pattern of productivity or the same level of activities because the assumption is that positive self-concept and societal value of older adults could only come from work or productivity. In other words, there is only one way to achieve successful aging, which is keeping what the older adults always did, projecting engagement and accomplishment, with no room for self-determination. One might conclude that activity theory provides the foundation for policies such as delayed retirement ages to keep pattern going. Supporters of activity theory recognize that, with all the flaws in its premise, it demonstrates theoretical possibilities to further develop into a framework for social engagement and social health in later life. For example, 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).

Over the years, activity theory has become a vehicle to conceptualize social connectedness. For example, when de Leon, Glass, and Berkman (2003) and Glass, de Leon, Bassuk, and 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. Recently, Mackenzie and Abdulrazaq (2021) differentiated social (activity) participation from social engagement. However, they operationalized social participation as a 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 matters with.

Continuity in Aging

Continuity theory was developed through a longitudinal study by Atchley (1999). 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). Among all 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. According to continuity theory, continuity in internal constructs, lifestyles, and relationships not only facilitates older adults in maintaining social contacts and connections, but also benefits them in developing the mature form of themselves and achieving ego integrity. Continuity theory has the strengths in its emphasis on social needs and human agency of older adult. It was applied into 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, rather than individuals within the social environments. The implication of continuity theory for policy making leads to an individualistic approach to solve any aging related issues and discourages any help-seeking behavior.

Social Networks

Efforts were made to go beyond the individualistic approach and capture multidimensional nature of social connectedness in older adults. Such efforts can be represented by social network instrument constructs that seek to measure mainly subjective social connectedness in older adults. The Berkman-Syme Social Network Index (BSNI) and the Lubben Social Network Scale (LSNS) are results of these efforts. The notion of social networks in these instruments is a quantifiable term for the total quantity and quality of social connections. They intend to measure the structure, content, and 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. For instance, support networks provide emotional, instrumental, informational, and appraisal support.

Although the BSNI and the LSNS each has a distinct focus, both include multidimension of objective social connectedness between older adults and their individual relationships, 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, and the better is their social health. A cautionary tale is that the social network literature is often under the shadow of the disease orientation, which turns the focus of social networks from social connectedness to social isolation and loneliness, rather than social connectedness in older adults (Steinman et al., 2021).

Social Support

Social support indicates social connectedness of older adults in many ways and it 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). 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 four dimensions of functional support: Emotional, instrumental, informational, and appraisal support.

Social Inclusion

It is evident that social networks and contacts with family and friends, social support, and engagement in leisure and social activities are health assets, and that they promote the healthy

aging and subjective well-being (Chamers et al., 2022; Homby-Turner, Peel & Hubard, 2017). However, personal objective and subjective social connectedness does not fully explain social health in aging. An attempt to break through the individualistic orientation in investigation of social connectedness is a new attention to macro environmental factors in social health in aging. It embraces both individual agency and community wellbeing. it emphasizes social inclusion and appreciates and interprets senses of community and belonging in aging experience, as well as institutional inclusion that provides the social environment facilitating and protecting social inclusion (Glass, 2016; Koelen, Eriksson, & Cattan, 2017).

Institutional Inclusion

The notion of *institutional inclusion* asserts that the social structure and institutional intentionality are necessary elements to develop social infrastructure and built environment where older adults can best connect with their social relationships and themselves, no matter what their personality traits, physical conditions, mental capacity, or their personal and collective identifies are. With renewed understanding of social environmental factors of health, new discoveries in gerontology and geriatrics, and technological advancement, the society, social gerontology included, 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 (AFC) Movement signifies one of the positive developments in this social inclusion effort. Different from single program or system-based inclusive practice, 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 in social/civic/financial activities, enjoy outdoor spaces, have an age friendly built environment, and have access to transportation, healthcare, and technology. In the purposefully designed age friendly

community/city, older adults can be respected as fellow citizens. 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 (WHO, 1948). Emerging data show that older adults in the AFC on the average rate health better than their counterparties in the non-AFC and that AFCs have better crisis responses to older adults' food, social connection, technology utilization, and emergency preparedness (Dabelko-Schoeny et al., 2022; Kim, Buckley, Burnette, Huang, & Kim, 2022).

Intergenerational Inclusion

For the first time in history, families with 4-5 generations became more prevalent than ever before. Inter-and intra-generational relationships, including grandparents-grandchildren bond, can be a rare asset for all generations in the families and the society (Klein, 2022). Policy and built environment are called to disrupt monogenerational social arrangements and include and promote inter- and intra-generational interaction and inclusion. The literature has documented three categories of intergenerational inclusion endeavors. One is organization-based intergenerational programs, such as Children-older adults intergenerational programs at day care centers, and adolescents or adults-older adults intergenerational programs at nursing homes (Krout et al., 2010; Laging, Slocombe, Liu, Radford, & Gorelik, 2022; Low, Russell, McDonald, & Kauffman, 2015; Norouzi & Angel, 2023; Norouzi, Swenson, & Harvey, 2022). Another is inter- and multigenerational built environment design and policy interventions that promote cross-generational interaction in public space. Multigenerational built environment designs to not only meet the needs of both youth and older adults, but also make older adults visible in the public space (Nelischer & Loukaitou-Sideris, 2023). It architecturally and socially promotes acceptance and celebration across generations. The third endeavor is modernized

multigenerational housing that organically builds generational interaction and coherence in daily life (Gardner, Geraldine, & Nasserjah, 2020; Kim, Baek, Garcia, & Wen, 2023). Although generational inclusion in education, healthcare, workplace, and public space is still in its infancy and facing mountainous barriers, benefits and opportunities are tremendous for both older adults and the society.

Social Determinants of Social Health

Early social theories examined in this chapter have studied social relationships of older adults through the lens of the white majority. Methodologically, they built their theoretical frameworks on white, middle class older adults and neglected human diversity in aging. For example, activities in the Kansas City Study were middle-age activities or work-related activities. They overlooked other variables that predict life satisfaction, such lifelong experiences, SES, culture, generations, personality, and functioning or abilities. It is evident that active older adults generally are better educated and have more resources and options than their less-active counterparts. Similarly, continuity theory missed the mark when considering individuals who may be leaving work to take on other roles- such as caretaker for grandchildren.

Volunteerism is another example that social theories overlook social factors in social health. Volunteerism has a special place in activity theory. However, research regarding the role of volunteerism in aging often disregards informal volunteer activities such as supporting neighbors even though they are a core element of life for Latinx and African Americans (Johnson & Lee, 2017; Baker et al., 2014). Case Study 7.3 illustrates how volunteerism looks different among Black, Indigenous and People of Color (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.

The theory of social determinants of health takes diverse aging experiences, values, relationships, and social and built environments into account and facilitates our understanding and vision of social health in later life for diverse older adults (Pool, Agyemang, & Smalbrugge, 2017). The framework of *social determinants of health* (SDOH) articulated by WHO addresses the context, structural determinants, and intermediary determinants that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Health People 2030, n.d.; WHO, 2010). 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 subject sense of social connectedness (Cumming, 1963; Havighurst, 1968). Furthermore, social health in aging involves 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, found that older Latino adults tend to have larger families, stronger bonds and more interaction and support from their adult children (Burnette, 1999; Peek, Howrey, Ternent, Ray, & Ottenbcher, 2012). The aging LBTQ+ community tends to have higher rates of loneliness when compared to their heteronormative counterparts (Kuyper & Fokkema, 2009). For instance, in Case Study 7.2 Alfred's support system was small due to decades of prejudicial beliefs and family separation.

At the society level, hidden risk factors disproportionally threaten racial minority older adults, older adults living in low-income or poverty, older adults with disabilities, and

particularly older adults experiencing multiple social exclusion. For instance, socioeconomic factors, such as the largest generation of millennials entering the housing market, soaring housing price, and inflation, can contribute to homelessness in some older adults and force 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 (Williams, Dakin, & Lipschutz, 2022). 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 access, and disease management and prevention. Recent evidence shows that older black and brown adults in age friendly communities have worsening self-rated health than their white counterparts (Kim, Buckley, Burnette, Huang, & Kim, 2022). The pervasive and persistent racial inequity in age- inclusive efforts is a wakeup call for greater and sustaining actions for rights and optimal well-being of minority older adults for the happiness and security of all people. In conclusion, all evidence suggests that the social and built environments great impact social health of older adults and the social health in aging can also make great contribution to the well-being of society at large.

Chapter Summary

Social rights and needs of older adults are fundamental to their optimal health in later life. Building upon the WHO's 1948 definition of health, this chapter proposes an operational definition of social health beyond absence of social isolation and loneliness at individual levels. It examines social exclusion through age-segregation and digital exclusion. It traces the ageist roots of social exclusion in early social gerontological frameworks that contribute to social construction of social exclusion. Through the lenses of critical gerontology and social determination of health, this chapter explores personal social connectedness and institutional

social inclusion as two conditions of social health in aging and analyzes social and built environmental factors of social health in older adults. Special attention is giving to older adults experiencing multiple social exclusion.

Chapter 7 Review Questions

1. What are three social health diseases the chapter analyzed?

    A. Disengagement, Role Theory, Activity Theory

    B. Digital Exclusion, Age Segregation, Social Exclusion

    C. Social Exclusion, Social Isolation, Loneliness

    D. Monogenerational Environment, Ageism, White Supreme

2. What are key elements of social connectedness?

    A. Social Support, Healthy Aging

    B. Social Networks, Social Support, Social Inclusion

    C. Social Networks, Social Support, Sense of Community

    D. Intergenerational Inclusion, Social Support

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

4. What does social health look for you at your age and when you are at 85?

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 differences you would like to see at the university/college you are with to make it an age friendly university?
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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