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James Lubben
Boston College

Melanie Gironda
University of Southern California

Erika Sabbath
Boston College

Jooyoung Kong
Boston College

Carrie Johnson
Boston College

American Academy of Social Work and Social Welfare
aaswsw.org

Grand Challenges for Social Work Initiative

The Grand Challenges for Social Work are designed to focus a world of thought and action on the most compelling and critical social issues of our day. Each grand challenge is a broad but discrete concept where social work expertise and leadership can be brought to bear on bold new ideas, scientific exploration and surprising innovations.

We invite you to review the following challenges with the goal of providing greater clarity, utility and meaning to this roadmap for lifting up the lives of individuals, families and communities struggling with the most fundamental requirements for social justice and human existence.

The Grand Challenges for Social Work include the following:

- Ensure healthy development of all youth
- Close the health gap
- Stop family violence
- Eradicate social isolation
- End homelessness
- Promote smart decarceration
- Reduce extreme economic inequality

- Build financial capability for all
- Harness technology for social good
- Create social responses to a changing environment
- Achieve equal opportunity and justice
- Advance long and productive lives

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James Lubben, Melanie Gironda, Erika Sabbath, Jooyoung Kong, and Carrie Johnson

Solid epidemiological evidence links social isolation to health. Both the World Health Organization and the U.S. National Institutes of Health have affirmed the importance of addressing social isolation. The AARP also has recently adopted social isolation as one of its top five new initiatives. Working in tandem with other key professions, social work possesses the unique expertise to greatly reduce the risk and consequences of social isolation. The "social" element of social work is the key for solving the grand challenge of reducing the risk of social isolation and strengthening social ties among all populations.

Key words: Social isolation, social connections, social networks, social support, social functioning, loneliness, health risks, social work

SOCIAL ISOLATION IS A COMPELLING CHALLENGE FOR SOCIAL WORK

Social isolation is a potent killer. Public health experts (House, 2001) now posit that the association between social isolation and health is as strong as the epidemiological evidence that linked smoking and health at the time U.S. Surgeon General C. Everett Koop issued his now-famous warning. The health risks of social isolation are often studied in older populations, but isolation can be deadly for the young (e.g., the many school shootings perpetrated by individuals described as socially withdrawn). Thus, it is appropriate for social work to strategically address the challenge of social isolation. Working in tandem with other key professions, social work possesses the unique expertise to greatly reduce the risk and consequences of social isolation.

Evidence suggests that Americans are more socially isolated now than ever before. In a study that compared network structures from 1985 to those of 2004, McPherson, Smith-Lovin, and Brashears (2006) found that Americans were connected far less tightly. The number of people in the study who reported not having anyone with whom to discuss important matters nearly tripled, and the mean network size decreased from an average of 2.94 to 2.08 people per person, with fewer contacts through voluntary associations and neighborhoods.

Among both young and older adult populations, social isolation has been linked with a wide array of health problems ranging from susceptibility to the common cold (Cohen, 2001; Cohen et al., 1997) to the ability to survive a natural disaster (Pekovic, Seff, & Rothman, 2007; Semenza et al., 1996). A number of researchers have demonstrated how inadequate social support networks are associated with increases in both morbidity and mortality (Berkman, 1984, 1986;

Berkman & Syme, 1979; Bosworth & Schaie, 1997; Blazer, 1982; Ceria et al., 2001; Ell, 1984; House, Landis, & Umberson, 1988; Rook, 1994; Zuckerman, Kasl, & Ostfeld, 1984). Other scholars reported an association between limited social ties and poor overall health and well-being (Chappell, 1991; Krause, Herzog, & Baker, 1992; Lubben, Weiler, & Chi, 1989; Rook, 1994; Stuck et al., 1999). More have documented a connection between social support networks and adherence to desired health practices (Potts, Hurwicz, Goldstein, & Berkanovic 1992). Social isolation has been associated with increased symptoms of psychological distress or loneliness, which may be risk factors for future disease and disability (Dorfman et al., 1995; Lin, Ye, & Ensel, 1999; Thoits, 1995; Turner & Marino, 1994; Wenger, Davies, Shahtahmasebi, & Scott, 1996).

EVIDENCE INDICATES THAT SOCIAL ISOLATION CAN BE REDUCED

As a result of this overwhelming body of evidence, a special committee at the National Institutes of Health (National Research Council [NRC], 2001) issued a report in 2001. It identified a domain of behavioral and social sciences research questions whose resolution could lead to major improvements in the health of the U.S. population. The NRC report listed *personal ties* as one of the top ten priority areas for research investment that could lead to major health improvements. It summarized a growing body of epidemiological findings that link social relationships with mental and physical health outcomes, including mortality. Furthermore, the report explored how disruption of personal ties, loneliness, and conflictual interactions produce stress, and discussed how supportive social ties are vital sources of emotional strength.

Since the publication of the NRC report, evidence regarding the impact of social isolation on various measures of morbidity and mortality has grown even stronger (Berkman, 2014; Berkman et al., 2004; Eng, Rimm, Fitzmaurice, & Kawachi, 2002; Giles, Glonek, Luszcz, & Andres, 2005; Holt-Lunstad, Smith, & Layton, 2010; Lubben et al., 2006; Pantell et al., 2013; Schnittger, Wherton, Prendergast, & Lawlor 2012; Zhang, Norris, Gregg, & Beckles, 2007). Similarly, researchers have further documented the negative consequences of social isolation on mental health (Adams, Sanders, & Auth, 2004; Alspach, 2013; Chen et al., 2012; Esgalhado, Reis, Pereira, & Afonso, 2010). There has also been increased evidence of the impact of social isolation on self-reported health and well-being (Chan, Malhotra, Malhotra, & Ostbye, 2011; Giuli et al., 2012; Kimura, Yamazaki, Haga, & Yasumura, 2013; McHugh & Lawlor, 2012; Schnittger, Wherton, Prendergast, & Lawlor, 2012).

Social isolation in children and youth

Models of attachment and social functioning that are formed early in life may have profound impacts on the ways that individuals interface with the social world throughout their lives (Bowlby, 1964). Those early attachments in turn inform one's ability to form and maintain strong relationships. Research suggests that the sensitive period in which social connections can most benefit health and well-being may occur at younger ages than was once hypothesized

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(Berkman, 2009). For example, strong social support networks are particularly important to mental health and preventing behavioral problems (McPherson et al., 2014). In particular, social isolation has been associated with increased risk of depressive symptoms, suicide attempts, and low self-esteem in young people (Hall-Lande et al., 2007). In another large national child development study in the United Kingdom, researchers found that social isolation in childhood is associated with higher levels of C-reactive protein (an indicator of coronary heart disease) in mid-life (Lacey et al., 2014). Finally, social isolation in younger people may ultimately threaten the safety and well-being of others when emotions are externalized. This has been documented in the cases of many adolescent mass murderers who were retrospectively described as socially isolated or ostracized from peers (Levin and Madfis, 2009).

Social isolation in older adults

Social isolation among older adults is becoming increasingly recognized as a critical issue worthy of more attention. Recent research has demonstrated that social isolation is a significant risk factor for cognitive impairment and dementia (Crooks, Lubben, Petitti, Little, & Chiu, 2008; Ertel, Glymour, Berkman, 2008; Maki et al., 2013; Seeman, Lusignolo, Albert, & Berkman, 2001). Acierno et al. (2010) found that low social support increased the likelihood of elder mistreatment, which, in addition to the human costs of such abuse, carries financial costs of approximately $12 million dollars annually (Dong & Simmons, 2011) according to the Government Accounting Office. Two specific isolating factors tied to the increasing risk of elder mistreatment include loss of friends and perceived social alienation from the community (von Heydrich, Schiamberg, & Chee, 2012). For some vulnerable older adults, living with a caregiver, particularly with a spouse, is also associated with an increased risk of abuse (Beach et al., 2005; Cooney et al., 2006; Paveza et al., 1992), suggesting that an isolated dyad, outside of a larger support structure, especially puts people at risk for being either the victim or potential perpetrator of mistreatment. Besides physical or mental abuse, socially isolated older adults are also highly vulnerable to financial scams and manipulations. A recent AARP report (AARP Foundation, 2012) provided synthesized research findings about social isolation in older populations. The report identified key risk factors for social isolation: physical or functional impairments, particularly for older adults who lack instrumental support (e.g., transportation); having low socioeconomic status; and poor mental health status (e.g., depression, cognitive impairments). As a result of the studies that document the consequences of social isolation on older populations, AARP initiated a campaign to raise awareness about social isolation and stimulate more intervention research on the topic (AARP Foundation, 2012).

The impact of social networks

Berkman and associates (Berkman & Glass, 2000; Berkman, Glass, Brissette, & Seeman, 2000; Berkman, Kawachi, & Glymour, 2014,) have proposed four key pathways to explain these increasingly apparent links between social isolation and health. They argue that social networks affect an individual's health and well-being through one or more of the following possible social and behavioral mechanisms: (1) provision of social support, (2) social influence, (3) social

engagement and attachment, and (4) access to resources. For example, social networks may provide essential support needed during times of illness, thereby contributing to better adaptation and quicker recovery time. Social ties can be instrumental in adherence to good health practices and the cessation of bad ones (Kelsey et al., 1997; Potts et al., 1992). Strong social bonds may offer a stress-buffering effect that reduces the susceptibility of an individual to stress-related illnesses (Cassel, 1976; Cobb, 1976; Krause et al., 1992; Mor-Barak, Miller, & Syme, 1991; Thoits, 1982). Social connections might also provide improved access to important resources such as relevant health knowledge, timely care, or transportation to and from health-care appointments. More recent research explored possible direct biological effects of social ties on human physiology, perhaps by stimulating the immune system to ward off illnesses more effectively (Seeman, Singer, Ryff, Dienberg Love, & Levy-Storms, 2002).

The research on social isolation has made remarkable progress since Lisa Berkman and Leonard Syme published their seminal article in the American Journal of Epidemiology in 1979. Their research examined the connection between social networks and mortality among a general adult population (Berkman & Syme, 1979). They constructed the Berkman-Syme Social Network Index (SNI) for this research by summing up whether or not a respondent (1) was married, (2) belonged to a church or temple, (3) participated in clubs or organized groups, and (4) had social contact with family or friends (Berkman, 1983). Remarkably, this relatively simple SNI measure was significantly correlated with mortality rates in this nine-year follow-up epidemiological study.

Shortly thereafter, health researchers across the board scrambled to replicate these results using various proxies for social networks. Some of the selected proxies (e.g., marital status, living alone) failed to capture important nuances of social connections, so health researchers spent the 1980s and '90s refining measures for social networks and supports. The central goal of this process was to determine which aspects of an individual's social connections should be measured, and which dimensions or perceptions of those relationships were particularly relevant for predicting subsequent morbidity and mortality.

Primary and secondary social groups

Primary social groups (e.g., family, friends, neighbors) are the foundation of social ties, particularly in youth and old age. Family is generally considered the most central primary group to which an individual belongs. However, intimate friends can also be as vital as family ties, especially when family relations are strained or deficient for other reasons. Alternative family arrangements and the formation of nonmarried couples—especially as social norms and practices of family formation change—impart new complexity to quantifying social connections.

Secondary social groups include membership organizations such as recreational or culture clubs, professional societies, and various political and religious organizations. The workplace is an important forum for social relationships and, for individuals who are otherwise isolated, can serve as a regular form of social contact and connection.

The distinction between primary and secondary social groups is relevant to understand major approaches to measuring social isolation. For example, many social researchers tend to examine social networks through a lens that measures participation in social activity and organizations. Meanwhile clinical researchers have largely focused on primary social groups. The SNI (Berkman & Syme, 1979; Pentell et al., 2014), a common instrument in public health research, is a classic example of a measure that emphasizes secondary social groups. The Lubben Social Network Scale (Lubben, 1988; Lubben & Gironda, 2003; Lubben et al. 2006; Rubenstein, Lubben, & Mintzer, 1994) is an example of a measure of social isolation that focuses on primary group membership, so it has found favor with practitioners and clinical researchers.

Although there are differences in their focus, researchers can now draw from a wide array of social network measures with excellent psychometric properties (Berkman et al., 2014). Remarkably, the connection between social isolation and health remains quite consistent despite the lack of consistency in both defining social support networks and also measuring health outcomes. Such diversity of studies adds additional significance to the convergence of their findings.

Negative impacts of social isolation

In 2001, House concluded that social isolation kills, but how and why it does damage was very much unknown. The developmental periods in which isolation may disproportionately affect later disease risk was also very much unknown (House, 2001). Additionally, the extent to which social isolation's health effects are reversible if isolation itself is successfully reduced remained very much unknown (House, 2001).

Since 2001, researchers have made progress in understanding these basic questions. Nicholson (2012) recently reported a systematic review of 70 studies that examine the negative impact of isolation on a wide array of outcome measures. He concluded that social isolation is an important but under-assessed condition, as well as a risk factor for other conditions. Dickens et al. (2011) published a systematic review of 32 intervention studies that target isolation among older adults. Although some intervention trials failed to modify desired behaviors or downstream health outcomes (e.g., ENRICHD Investigators, 2001), other clinical interventions have reported success (e.g., Nicholson, 2009. Overall in their systematic review, Dickens et al. (2011) found that 79% of group-based interventions and 55% of one-on-one interventions reported at least one improved participant outcome.

Social isolation in health-care settings

Although there is extensive evidence that links social ties to health and well-being, this body of research is only beginning to translate to changes in social work practice (Gironda & Lubben, 2002). In health-care settings, minimal attention is given to social health status compared to that of other attributes people presents when seeking care. More specifically, the health-care system

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shows much more regard for the physical and mental health dimensions of patients while giving only minor attention to the social health dimensions of patients.

As identified in *Introduction and Context for Grand Challenges in Social Work* (Sherraden et al., 2014), when comparing social and health expenditures, the ratio averages 2:1 among the Organization for Economic Co-operation and Development (OECD) countries; however, it is only 0.8:1 in the United States, indicating that health spending is crowding out social and educational spending (Kaplan, 2013). This marginal concern for social health is demonstrated in many health-care encounters but is especially apparent in assessment protocols. For example, geriatric assessment is the "heart and soul" of geriatric practice (Solomon, 2000, p. ix). However, very few components of geriatric assessment instruments deal with social health matters, suggesting that they are not currently perceived to be central to geriatric practice.

Therefore, indicators of a person's social health should be as much a part of assessment protocols as are mental and physical health markers (Lubben & Gironda, 2003; Pentel, et al., 2013). In an era that stresses community-based delivery of health care, members of a person's social support network are often more responsible for successful execution of treatment plans than members of the formal health-care team. For isolated older adults, social supports often end up being the in-home care managers who monitor compliance with treatment regimens and provide early detection of new problems that require intervention.

Increased sensitivity to the importance of social support networks might help flag those individuals in need of a more comprehensive assessment from a social worker or another health or mental health care practitioner. As community health nurses are being urged to screen home health clients and assisted living residents for social isolation (Tremethick, 2001), other practitioners should be encouraged to similarly adopt such practice protocols. A practitioner's focus on the importance of social connections can also increase the patient or client's attention to his or her own social health.

MEANINGFUL AND MEASURABLE PROGRESS TO ADDRESS SOCIAL ISOLATION CAN BE MADE IN THE NEXT DECADE

The coming decade provides an opportunity to develop and test specific interventions that rebuild the fabric of frayed social connections in both older adults and younger people. With a Grand Challenge focus on social isolation, social workers could better consolidate the existing knowledge about social isolation and initiate a paradigm shift in the practice community. The possibilities of such a concerted effort are suggested in a website launched by AARP that provides practical hints regarding what can be done to address social isolation (AARP, 2012). Another approach for aging populations can be found in the WHO Age-Friendly Communities movement (WHO, 2007). In the United States, the Village models of age-friendly communities attempt to fabricate new social ties to replace those lost or frayed among older adults wishing to remain in their long-term communities as they age (Scharlach, Davitt, Lehning, Greenfield & Graham, 2014).

Another example of efforts to modify social work practice can be gleaned from an open access social isolation module developed by the Boston College Institute on Aging (2014) in conjunction with the Hartford Center of Excellence at the Boston College School of Social Work. This online module includes two YouTube videos and a number of links to other references that inform both lay and professional people about the importance of addressing social isolation and offers suggestions for interventions. For example, one video provides a summary of research evidence regarding the health risks attributable to limited social connections. The other video is entitled "A Practitioner's Perspective on Social Isolation" and, as the title implies, it provides useful suggestions on how social workers and others could modify their practice protocols to better address social isolation. The Boston College Institute on Aging's online module has been used by health and social agencies to train their professional and paraprofessional staff on interventions addressing social isolation and is available to the general public.

Examples of innovative approaches to address isolation among younger populations also exist. Social isolation in children and youth differs from that of adults in that children and youth have certain mandates for social participation, namely enrollment in educational programs that offer some degree of social inclusion. Accordingly young people differ from adults in terms of how and where they develop social connections (Morgan, 2010). Strong school connectedness has been shown to reduce the risk of depressive symptoms, suicide attempts, and low self-esteem among youth (Hall-Lande et al., 2007).

Researchers have also demonstrated a link between childhood trauma and health effects of social isolation in later life. In a study to examine whether perceived social isolation moderates the relationship between early trauma and pulse pressure (a marker for cardiovascular health), findings showed that those with higher levels of perceived social isolation showed a significant positive association between childhood trauma and pulse pressure (Norman et al., 2013). Accordingly, more attention is required to assess for social isolation among the victims of child abuse and neglect. Violence, including bullying among children and youth, also has a social isolation component. The Centers for Disease Control launched a new program to reduce youth violence that includes a component that attempts to build positive relationships between youth and adults and peers (David-Ferdon & Simon, 2012).

MEETING THE CHALLENGE OF SOCIAL ISOLATION WILL REQUIRE INTERDISCIPLINARY AND CROSS-SECTOR COLLABORATION

The approach to solve social isolation needs to be more inclusive and incorporate diverse populations. Studies of social isolation tend to focus on older populations, but social isolation is an important issue for all ages. In addition, researchers should pay more attention to socially marginalized groups. This will require an interdisciplinary, multisystem approach that considers social isolation not only at the individual level, but also in the familial, community, and societal levels. For example, enhancing social inclusion for older adults has to be a part of creating aging-

friendly community environments, which will provide more sustainable and comprehensive solutions for the population (Scharlach, Graham, & Lehning, 2011).

Similarly, there will need to be more interdisciplinary cooperation to address the complexity of social isolation. Much of the scholarship to date has been conducted in disciplinary silos, but cross-sector and interdisciplinary approaches are crucial for moving to the next level of understanding. A preliminary taxonomy of these disciplinary silos include (1) epidemiologists focused on identifying at-risk populations and subpopulations, (2) health service researchers focused on "controlling for" social isolation in their models rather than seeking to understand the phenomena, (3) biologists and neuroscientists examining biological pathways that account for the linkage between isolation and health consequences, and (4) clinical researchers focused on developing and testing interventions with limited capacity to digest all of the new information from the other disciplinary silos. Adopting social isolation as a Grand Challenge will motivate and empower social workers to take the lead on this enterprise and to break down these disciplinary barriers to improve the flow of knowledge and innovation across groups.

The role of social work

Social work is well positioned for interdisciplinary research on social isolation. Most schools of social work are housed at universities with easy access to other disciplines and professions, making them conducive to networking and collaboration. Given their community-based practice orientation, social workers are generally well integrated in communities. Social workers have been doing community-based and person-centered research for many years. . It has now become mandatory in clinical effectiveness research (CER) funded by Patient-Centered Outcomes Research Institute (PCORI) through the Patient Protection and Affordable Care Act of 2010. More specifically, key users of study information (e.g., patients, caregivers, clinicians, community members, policymakers) are now expected to be active members of the research "team" (Selby, Beal, & Frank, 2012).

Though this may be a new approach for some disciplines, social work researchers have a long history of community based participatory research with an interdisciplinary approach. Sabir et al. (2009) suggested community-based research on transportation barriers, psychiatric disabilities, varying types of communities, and multicomponent and person-centered interventions. Recommended future research priority areas include (1) the need to understand use of service (or more to the point, nonuse), (2) measures to identify isolated adults during a community crisis (e.g. , disaster relief), (3) evaluation of direct or indirect contact interventions, (4) efficacy of multicomponent interventions, (5) and research that reflects respect for continuing self-determination in older adulthood (Sabir, 2009). These are all areas of research in which social work has been involved that can accommodate an interdisciplinary focus.

Overcoming Social Isolation Requires Significant Innovation

Reducing the incidence of social isolation will require considerable innovation to develop and test individual and societal level interventions. For example, social workers can explore new social media technologies to test innovative interventions that reweave frayed networks and provide lifelines to vulnerable isolated individuals. As stated in *Context for Grand Challenges,* "It is not overstating to say that we live in a time of emergence of new social worlds of social media, social networks, and other social engagements via internet technology." (Sherraden et al., 2014, p. 5).

In addition, there is a critical need for innovative approaches that make use of new mobile technologies. For example, a recent Pew Research Center 2012 survey reported that fully 85% of adults in the United States own a cell phone. Of those, 53% own smartphones. One in three cell phone owners (31%) have used their phone to look for health information which is almost double the rate (17%) reported in a Pew survey conducted just two years earlier. Every major demographic group experienced significant year-to-year growth in smartphone ownership. This changing means of communication and information-seeking requires new approaches to reducing isolation that are nimble to our quickly evolving technological landscape.

At present, there is a multitude of mobile device health apps created for a variety of health issues. The challenge is to understand how information technology can be used to enhance social connections among vulnerable populations. The use of newer information and communication technologies (e.g., Internet social networking services) can be particularly beneficial for some groups to address social isolation. For example, several studies found that adults with physical and functional health decline combat loneliness and increase a sense of connectedness by using computers (Clark, 2002; Gatto & Tak, 2008; Sayago & Blat, 2010). In a review of literature that examines the potential for social networks and support to enhance tele-health interventions for people with a diagnosis of schizophrenia, most studies focused on improving medical adherence, providing medical information, and monitoring symptoms. However, the benefits of technology for mobilizing resources for self-management and peer support were evident, but more peripheral (Daker-White & Rogers, 2013).

Conclusion

In 1979, the World Health Organization (WHO) noted that social isolation needed to be addressed as a major health risk factor. Twenty-two years later, WHO reaffirmed the importance of addressing social isolation in a report on active ageing (WHO, 2002) and again in its Age Friendly Communities initiative (WHO, 2007). The importance of social ties—the inverse of social isolation—has been affirmed as a top-ten area for future National Institutes of Health research investment (NRC, 2001). The AARP has recently adopted it as one of its top five new initiatives (AARP, 2012). It is fitting and timely for social work to adopt social isolation as one of its grand challenges. Social work has the unique capacity to work with complex systems and

generate research that can bridge disciplinary silos that currently impede a complete understanding, and thus addressing, of social isolation.

The American Academy of Social Work and Social Welfare's adoption of social isolation as a grand challenge will undoubtedly elevate this domain among practitioners and their clients and patients. Indeed, the social element of social work is essential for solving the grand challenge of reducing the risk of social isolation among all populations.

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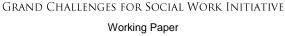
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ABOUT THE AUTHORS

JAMES LUBBEN[1] is the Louise McMahon Ahearn Professor in Social Work and the Director of the Institute on Aging at Boston College.

MELANIE GIRONDA is an Associate Clinical Professor in the Department of Family Medicine at the Keck School of Medicine and Associate Professor at Davis School of Gerontology.

ERIKA SABBATH is an Assistant Professor in the School of Social Work at Boston College.

JOOYOUNG KONG is a doctoral candidate and a teaching fellow in the School of Social Work at Boston College.

CARRIE JOHNSON is the Assistant Director of the Hartford Center of Excellence in the School of Social Work at Boston College.

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CONTACT

American Academy of Social Work and Social Welfare
Sarah Christa Butts, Assistant to the President

academy@aaswsw.org

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[1] Corresponding author. Email: lubben@bc.edu; office phone: 617-552-1366.