Promoting Social Connection to Improve Mental Health, Functioning & Wellness in Later Life

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Annual Conference of the Oregon Behavioral Health Initiative
June 16, 2021

MEDICINE *of* THE HIGHEST ORDER

UNIVERSITY *of* ROCHESTER MEDICAL CENTER

Disclosures & Acknowledgments

- I have no financial disclosures.
- Research funding:
  - CDC U01 CE001942 (Conwell, PI), The Senior Connection
  - NIMH K23MH096936 (Van Orden, PI), Socially Engage
  - NIA R01 AG054457 (Van Orden, PI), HOPE Project
  - NIA P30AG064103 (Heffner & Van Orden, MPI), Rochester Roybal Center for Social Ties & Aging Research

Learning objectives

1. Describe aspects of social connection that are linked to mental health and suicide risk in late

2. Describe the evidence base for strategies and programs to increase social connection and thereby improve mental health in later life

3. Identify three practical strategies they can take to their work to address social connection in their work.

Part 1. What is social connection & why does it matter?

Why make social health a priority?

- Social connections are essential for health and well-being at all ages.
- Being isolated and feeling lonely can lead to →
  - Poor mental health
  - Unhealthy behaviors
  - Poor physical health
  - Suicide ideation, attempts
  - Mortality (suicide & all cause)

A lifespan developmental perspective

- Stressors do accompany aging, but aging well is not the exception!
- Depression, loneliness, and suicide are not expected or normal responses to stresses of aging.

Developmental Trajectories
Emotional Well-Being Improves with Age

- Socioemotional Selectivity Theory (Carstensen & colleagues)
  - Aging makes time & endings come to the forefront
  - Prioritization of emotionally meaningful goals
  - “Positivity effect” in attention, relationships, mood
- Selection, Optimization, Compensation (Baltes & colleagues)
- Strength and Vulnerability Integration (SAVI; Turk-Charles & colleagues)

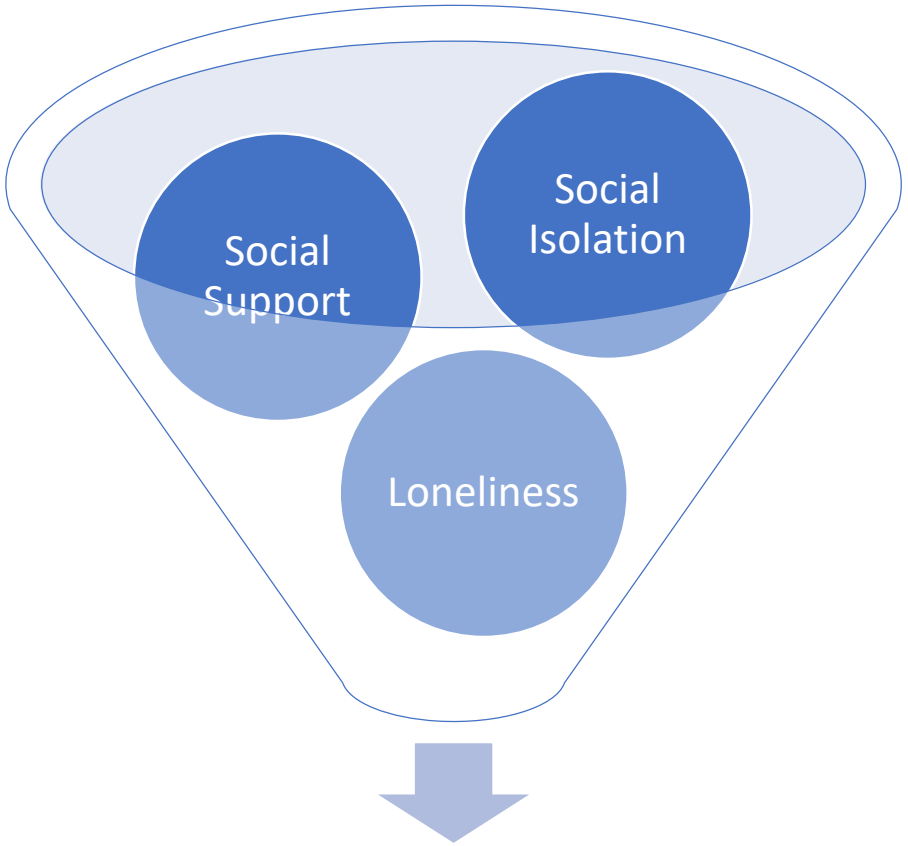
We know that social connection matters

- Social connections that create a sense of *caring*, *contributing*, and *community* have a range of benefits for health and well-being.

Holt-Lunstad, J., et al. (2017). "Advancing social connection as a public health priority in the United States." Am Psychol 72(6): 517-530.

Blazer D. Social Isolation and Loneliness in Older Adults-A Mental Health/Public Health Challenge. *JAMA Psychiatry.* 2020.

Definitions



Belonging, mattering, safety

There are three important parts to social connection:

how often and who you connect with

the support you get from your connections (e.g., for physical or emotiona support or for learning new information)

how you feel about our connections (e.g., feeling lonely or a sense of belonging).

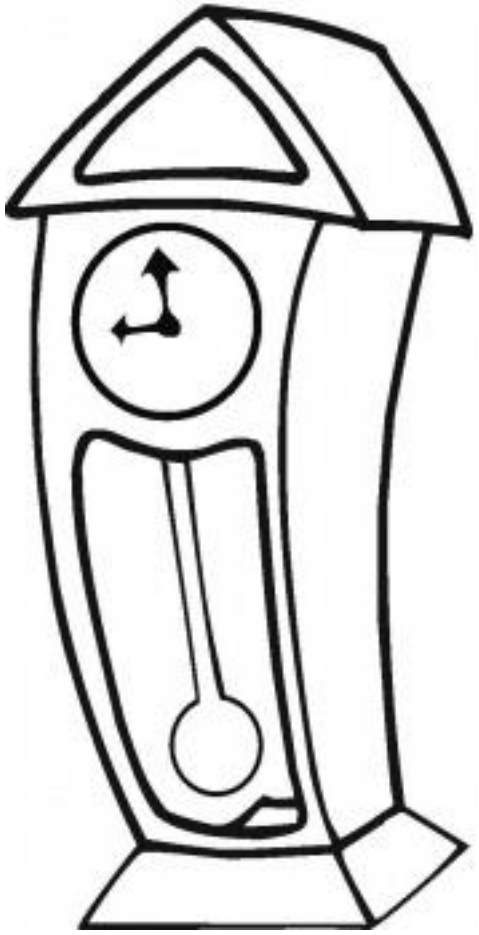
Social connection is when you connect with other people, either in person or from afar. For example, you can connect with friends, family, neighbours, pen pals or ever grocery store workers. You can also support your well-being with other types of connection, such as connecting with animals, with nature or through your faith.

Social networks as we age

- Social network size decreases
  - Fewer overall connections
  - Fewer friend connections
  - Number of family connections relatively stable
- “Pruning”
  - Fewer overall connections in friendship network
  - Greater investment and closeness in key meaningful relationships

Goals change across the lifespan

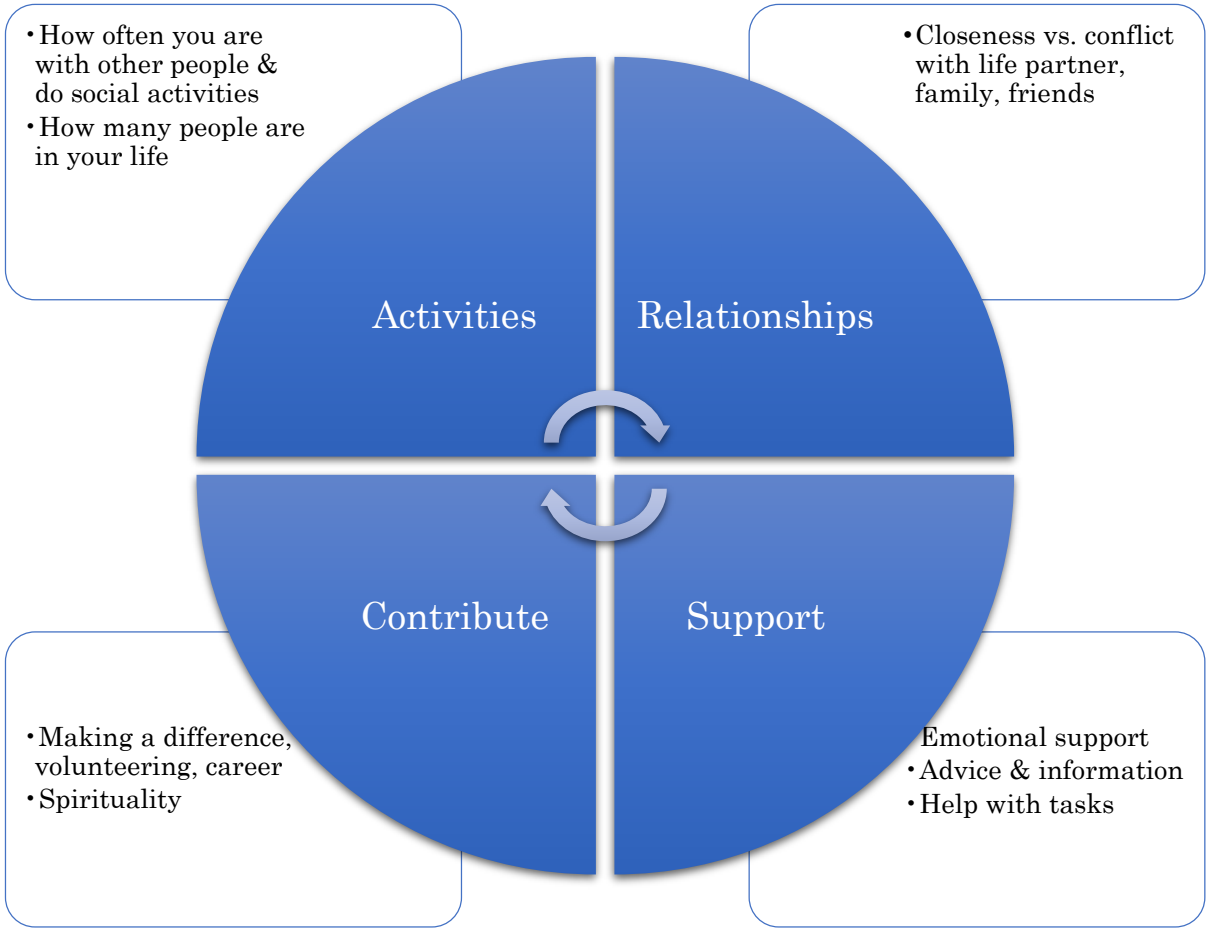
- Aging makes time and endings come to the forefront.
- Shifting priorities to what is meaningful now
  - Time perceived as open-ended: **knowledge**
  - Time perceived as limited: **emotion**
    - Prioritizing emotion regulation is one mechanism whereby emotional well-being increases with age
    - Positive social connections are key to emotion goals.



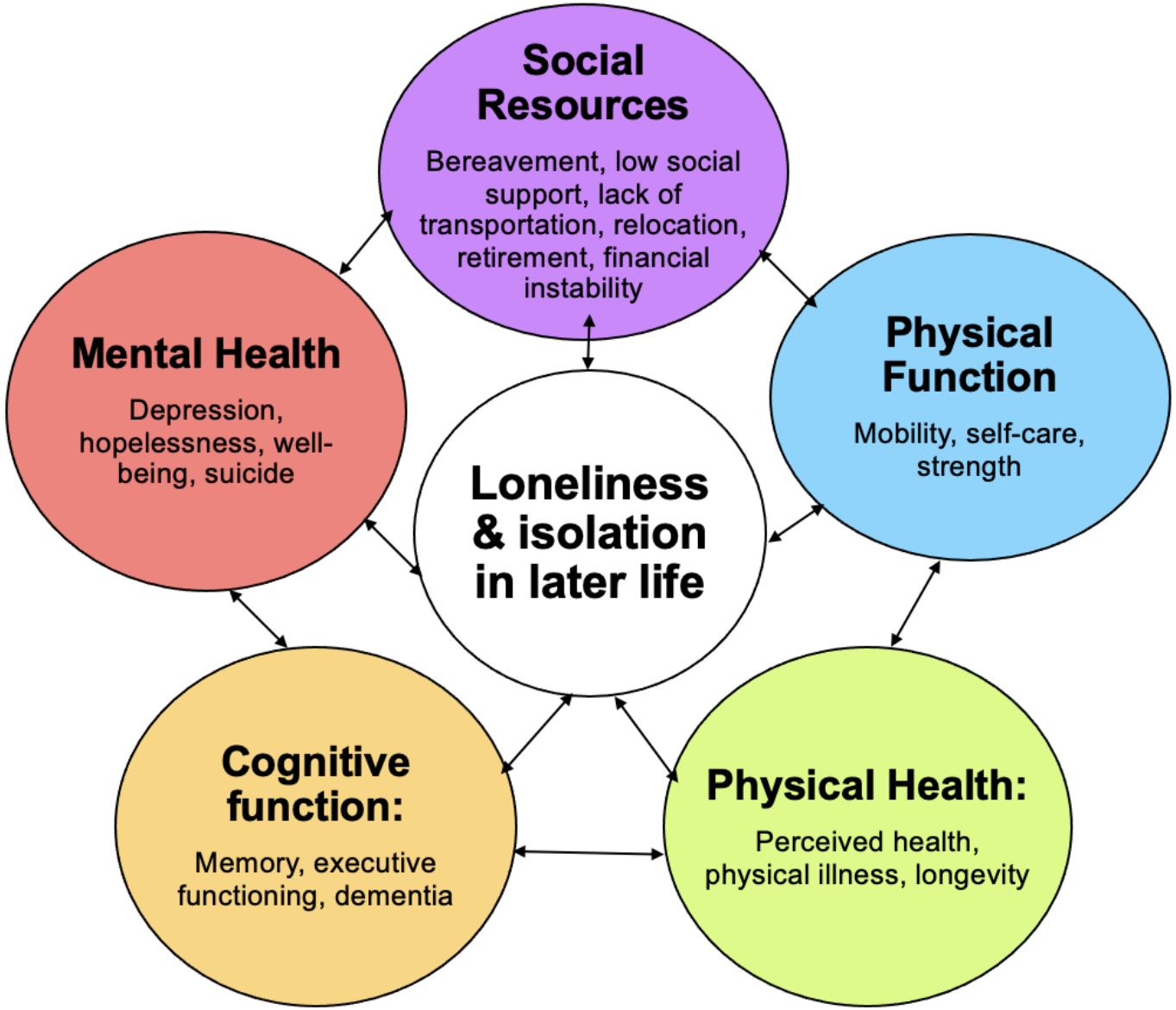
Carstensen, Isaacowitz, & Charles, 1999

Pie of Social Life

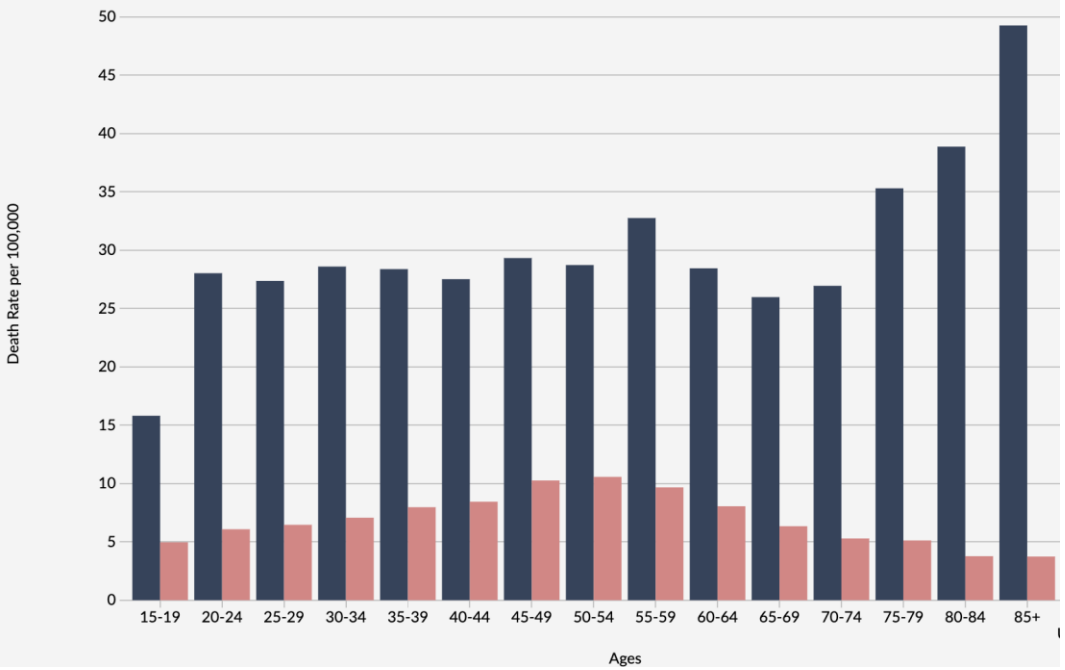
Consider the pieces of your social life now, how it was before the pandemic, and what you hope for the future. What pieces would be smaller? Bigger? Are pieces missing? How has the pandemic changed this?



We know that social isolation & loneliness have many causes and consequences



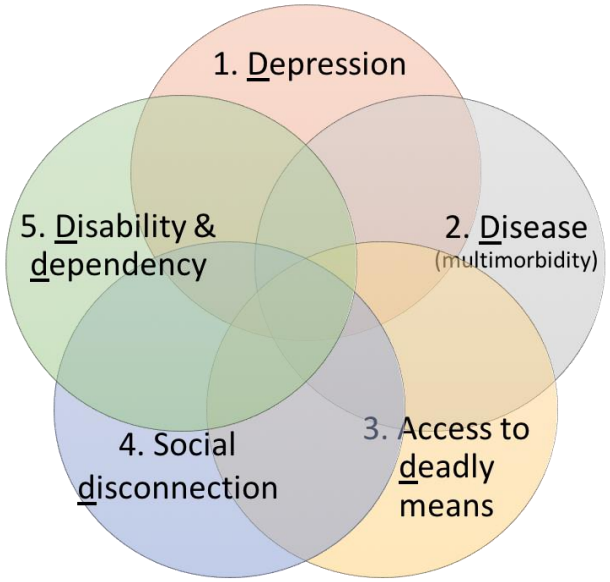
Late-life suicide



Suicide rates in the U.S. (2019)

- Older adults are the most rapidly growing segment of the population.
- Suicide rates increase with age around the world.
  - Older men in the U.S. have higher rates of suicide than other segments of the population.
  - In successive cohorts, the problem may increase.
- Suicidal behavior is more lethal in later life.
  - Optimal prevention should include upstream strategies.

5 Dimensions of Risk for Suicide in Late Life



1. Psychiatric illness (primarily depression)
2. Physical illness (multiple comorbid diseases)
3. Access to lethal (deadly) means (e.g., firearms)
4. Social disconnection (isolation, loneliness, family conflict)
5. Disability (functional impairment) & distress over dependency (feeling like a burden)

Conwell, Van Orden, & Caine (2011); Van Orden & Conwell (2011); Van Orden, Silva, & Conwell (2018)

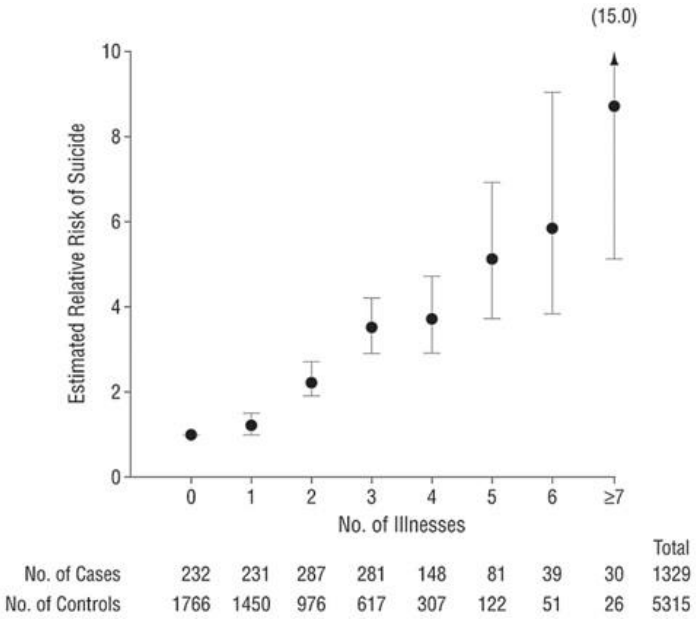
Depression: what we know

- Mood disorders (especially Major Depression) are the most common mental disorder among older adults who die by suicide: present in 54% to 87%
- Few older adults who die by suicide will have received formal psychiatric diagnoses or treatment.
- The combination of depressive disorders and medical illness is particularly common in later life and associated with suicide.
- Older adults are less likely to report sad/depressed mood and endorse instead anhedonia & apathy; more likely to describe somatic symptoms as their primary concern, including sleep, fatigue, psychomotor slowing, and problems with memory, concentration, processing speed, and executive functioning.

Depression: recent findings

- Mechanisms and pathways to depression in later life that can inform prevention (Santini et al., 2020, *Lancet Public Health)*:
  - social isolation → loneliness → depression (& bidirectional).
- Older adults may be more resilient than other age groups to mental health effects of the pandemic (Vahia, Jeste, Reynolds, 2020)
  - Older adults reported lower rates of new or increased suicidal ideation in the preceding 30 days (2%; Czeisler et al., 2020)
- Meta-analysis indicating a small, but reliable effect of collaborative care for reducing suicide ideation, especially when embedded psychotherapy is part of the CCM (Grigoroglou et al., 2021)

Physical illness: what we know



Juurlink et al., *Arch Intern Med 2004;164:1179-1184*

- Older adults who died by suicide are characterized by:
  - Decline in physical health in the year before death (primary care: Conwell et al., 2010 & long-term care: Murphy, Bugeja, Pilgrim, & Ibrahim, 2015).
  - Multimorbidity (Juurlink et al., 2004; Zhang et al., 2016)
  - Poor sleep quality (Bernert et al., 2014)
  - Commonly seen by their primary care physicians in the months and weeks before their deaths (Luoma, Martin, & Pearson, 2002).
  - The combination of depressive disorders and medical illness is particularly common in later life and associated with suicide.
- Inconsistency as to which specific diseases (or organ systems) are most strongly associated with suicide (Fassberg et al., 2016).
- Some illnesses may be associated with ideation, but not attempts or deaths.
- Potential mechanisms include: neurobiology of stress, neurobiology of illness, functional impairment (Conwell et al., 2009; Kim, 2016).

Disability: what we know

- Physical disability (also called functional impairment) is linked to suicide ideation, attempts, and deaths (Fassberg et al., 2016).
  - Greater numbers of both instrumental activities of daily living (IADLs) and activities of daily living (ADL) are associated with suicide.
- Sensory impairment, including vision loss, is also associated with suicide in later life (Waern, Rubenowitz, et al., 2002).
- Most with disability do not die by suicide; potential moderators:
  - Needing assistance with ADLs (use of visiting nurse services & home health aides; Conwell et al., 2009).
  - Long-term care residence & suicide (Mezuk et al.)
  - Personality characteristics (e.g., high need for control and autonomy; Kjolseth, Ekeberg, & Steihaug, 2009; O'Riley & Fiske, 2012)
  - Variety of coping strategies, applied flexibly (Wendell et al., 2016).
  - Internalized ageism associated with decreased will to live (Nelson, 2016)
- Complex association between suicide and cognitive functioning:
  - Dementia & suicide: typically soon after the diagnosis and early in the illness (Seyfried, Kales, Ignacio, Conwell, & Valenstein, 2011)
  - Cognitive control deficits increase risk for suicide attempts in later life (Szanto, 2017).

Physical illness & disability: recent findings

- Veterans with a history of stroke are at increased risk for suicide, specifically by firearm (Wyrwa et al. 2021)
- Meta-analysis indicating markedly elevated suicide rate among adults with HIV (Pelton et al., 2021)
- ICU survivors (v non-ICU hospital survivors) had a higher risk of suicide, especially those needing invasive mechanical ventilation & renal replacement therapy (Fernando et al., 2021)
- Increased risk for suicide death after cancer diagnosis, highest risk in first 6 months after diagnosis (Henson et al., 2018) through the first four years after diagnosis (Klaassen et al., 2019)
- Increased risk of non-fatal suicide attempt soon after MCI or dementia diagnosis (Gunak et al., 2021)
- The COVID-19 pandemic: suicide rates do not appear to have risen in the U.S. overall, though perhaps in some populations.
    - Signs that older adults fared better in terms of mental health
    - Hypotheses to be studied include Post-COVID syndrome (Sher, 2021)

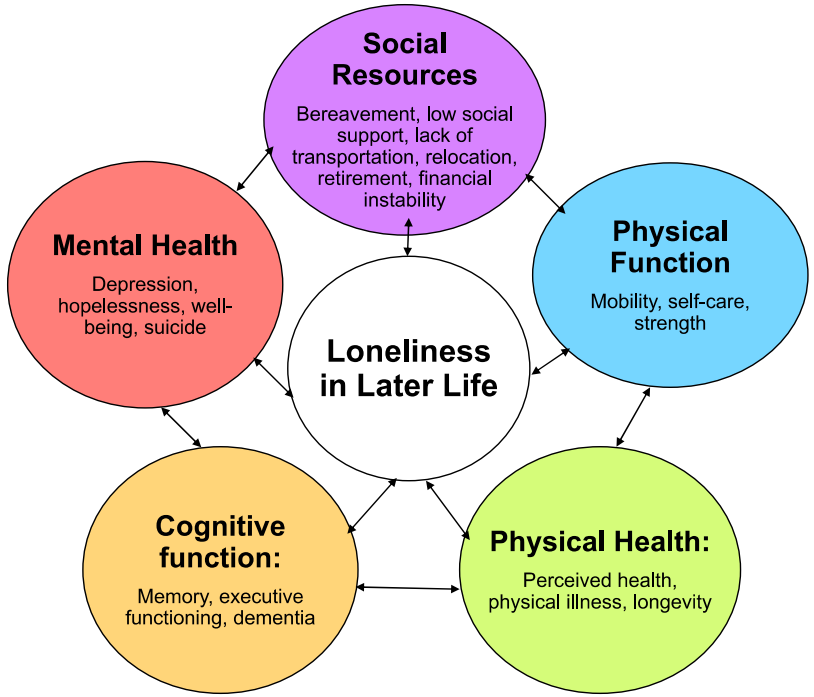
Firearms: what we know

- Suicide attempts are more often fatal among older adults, in part because older adults tend to use more lethal means (e.g., firearms in the United States), are more planful and determined, frailer, and often more isolated and thus less likely to be discovered before they have died (Conwell et al., 1990).
- Older adults in the United States who use firearms as the suicide method are more likely to live in rural areas and to have served in the military (Kaplan, Huguet, McFarland, & Mandle, 2012).
- Cognitive control deficits combined with access to lethal means may be a pernicious combination in later life.
    - Problem Adaptation Therapy (PATH) uses strategies from PST but shifts the focus to enhancing emotion regulation and includes environmental considerations and possible caregiver involvement (Kiosses et al.)
    - Safety Planning with older adults (Conti et al., 2020): www.mirecc.va.gov/visn16/collaborative-safety-planning-manual.asp

Firearms: promising directions

- Firearm safety counseling holds promise; Veterans find it acceptable for providers to restrict firearm access in those at risk for suicide (Theis et al., 2020)
    - Among Veterans with a suicide attempt seen in primary care, those age 50 and older were less likely to have been screened for impulsivity and firearms access and provided crisis services (safety planning, referrals for mental health services, and consideration of psychiatric hospitalization; Simons et al. 2019)
- Safe storage during crisis: Firearm Storage Maps (Kelly et al., 2020)
- Firearms advance planning: 1/5 of older adults surveyed had a plan for securing, removing, or transferring firearms if they became unable to handle them safely (Betz et al., 2021)

Social disconnection: what we know

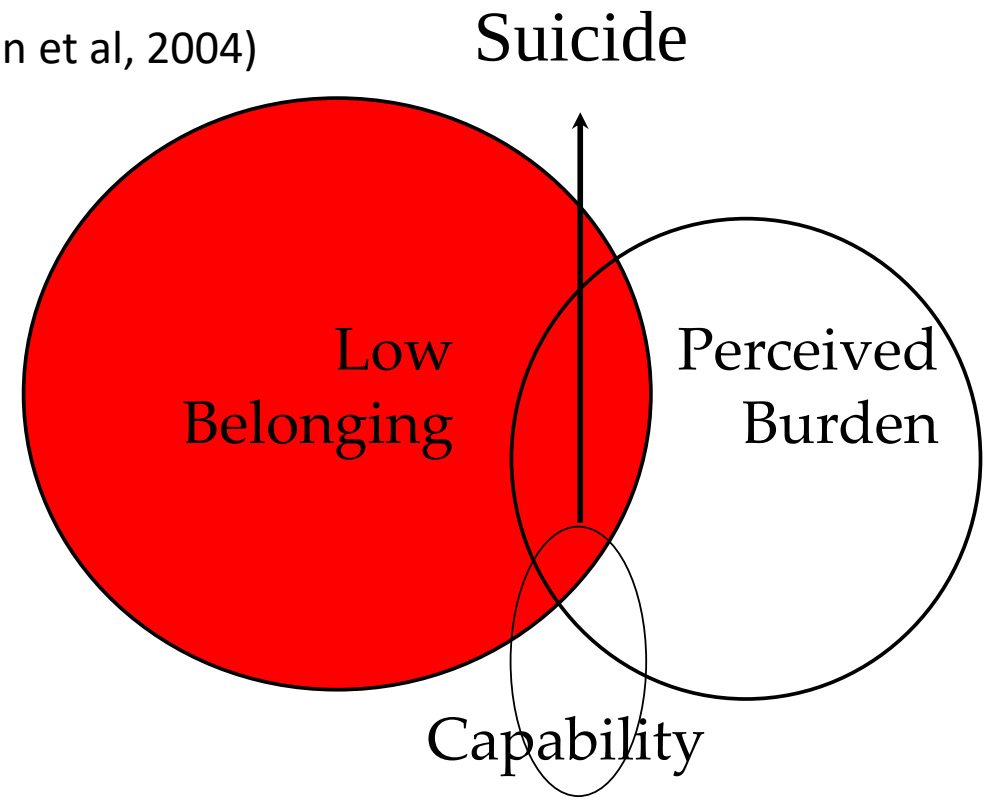


Van Orden (2021), AJGP

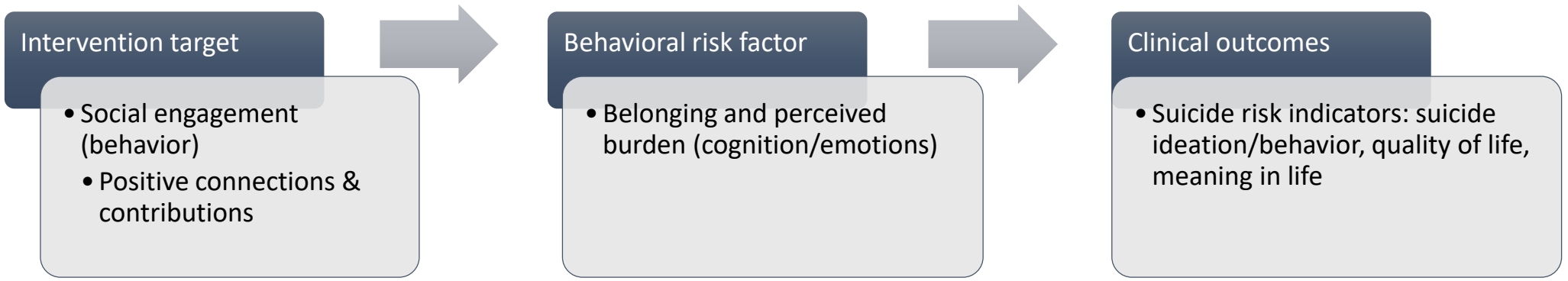
- Social connections that create a sense of *caring*, *contributing*, and *community* have a range of benefits for health and well-being (Blazer, 2020; Holt-Lunstad et al., 2017).
- Social isolation & loneliness are linked to suicide risk factors in later life as well as suicide ideation, attempt, and death.
  - living alone (De Leo et al., 2013)
  - small social networks (Tsoh et al., 2005)
  - the absence of a confidant (Turvey et al., 2002)
  - loss of a spouse (Conwell et al., 1990; Draper et al., 2014; Harwood et al., 2006)
  - social (dis)engagement, such as not participating in social clubs/activities (Rubenowitz et al., 2001).
  - family discord (Harwood et al., 2006; Rubenowitz et al., 2001; Waern et al., 2003)
  - loneliness (Rubenowitz et al., 2001; Waern et al., 2003).
  - Low levels of social integration have been demonstrated to have prospective associations with suicide mortality among both men (Tsai, Lucas, Sania, Kim, & Kawachi, 2014) and women (Tsai, Lucas, & Kawachi, 2015).
- Three intervention studies have shown effects on suicide deaths in older adults and all involved promoting social connection—but, the studies were not designed to test this mechanism (Chan et al., 2010; DeLeo et al., 2002; Oyama et al., 2008).

Social disconnection & suicide in later life

- **Loss of a spouse**
  (Conwell et al, 1990; Erlangsen et al, 2004)
- **Loneliness**
  (Rubenowitz et al, 2001)
- **Interpersonal discord**
  (Harwood et al, 2006; Beautrais, 2002; Duberstein et al, 2004)
- **Low social support**
  (Turvey et al, 2002)
- **Fewer people in whom to confide**
  (Miller, 1978)
- **Less community engagement**
  (Duberstein et al, 2004)
- **Living alone**
  (Waern et al, 2002; Barraclough, 1971)



Model of Intervention Mechanisms Grounded in The Interpersonal Theory of Suicide



Part 2. The evidence-base for strategies to promote social connection

Case vignette

- Ed is a 78 y/o white male who lives alone;
  - increasing disability (can no longer drive), possible depression, and reports feeling isolated from others.
- Care manager visited his home:
  - He reported a few acquaintances, but no close friends; family lives out of state.
  - Mild depression symptoms on depression screen
  - Smiles were rare; flat affect, monotone, minimal speech, long pauses, stooped over, fidgeted with hands, negative content in conversations.
  - He is reluctant to speak to a counselor.

HOW DO WE HELP?

Poll question #1:
Can behavioral interventions reduce loneliness & social isolation?

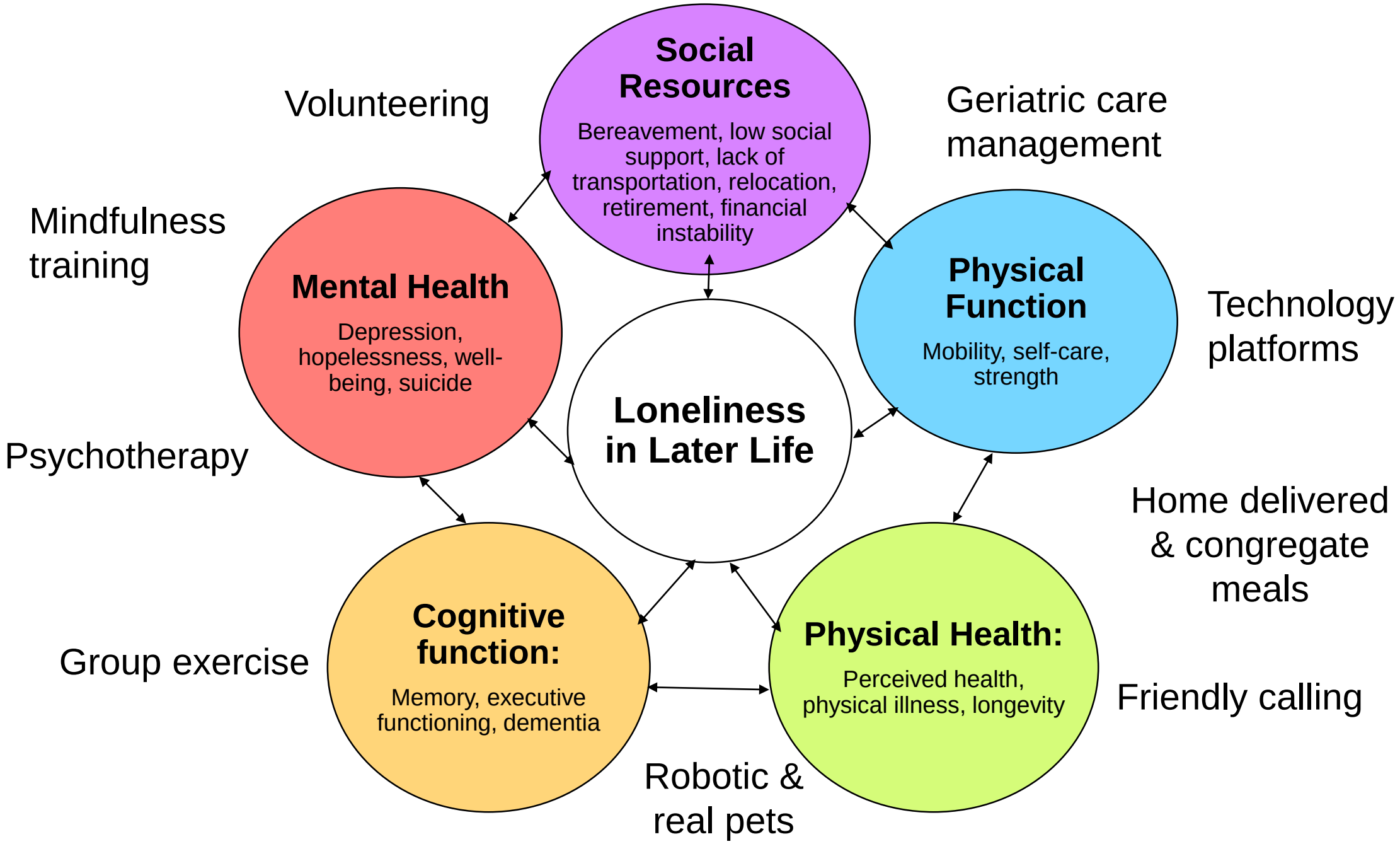
Yes

No

We don’t know yet

We know that behavioral interventions can reduce loneliness & social isolation in older adults

- Meta-analysis of behavioral interventions to reduce loneliness (Masi et al., 2011):
  - **Population:** all ages, not necessarily lonely at baseline:
  - **Design:** meta-analysis with 50 studies (all clinical trials not necessarily randomized controlled trials)
  - **Intervention:** behavioral interventions
  - **Results:** a small, but significant impact on loneliness.
  - Masi, C. M., et al. (2011). "A Meta-Analysis of Interventions to Reduce Loneliness." Pers Soc Psychol Rev 15(3): 219-266.
- Review papers describe the range of interventions:
  - Dickens AP, Richards SH, Greaves CJ, Campbell JL. Interventions targeting social isolation in older people: a systematic review. BMC Public Health. 2011;11:647.
  - O'Rourke HM, Collins L, Sidani S. Interventions to address social connectedness and loneliness for older adults: a scoping review. BMC Geriatr. 2018;18(1):214.
  - Findlay RA. Interventions to reduce social isolation amongst older people: where is the evidence? Ageing and Society. 2003;23(5):647-658.
  - Hagan R, Manktelow R, Taylor BJ, Mallett J. Reducing loneliness amongst older people: a systematic search and narrative review. Aging Ment Health. 2014;18(6):683-693.
  - Cohen-Mansfield J, Perach R. Interventions for alleviating loneliness among older persons: a critical review. Am J Health Promot. 2015;29(3):e109-125.
  - Cattan M, White M, Bond J, Learmouth A. Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. Ageing and Society. 2005;25(01):41-67.
  - Williams, C. Y. K., et al. (2021). "Interventions to reduce social isolation and loneliness during COVID-19 physical distancing measures: A rapid systematic review." PloS one 16(2): e0247139.


Social Resources
Bereavement, low social support, lack of transportation, relocation, retirement, financial instability
Volunteering
Geriatric care management
Mindfulness training
Mental Health
Depression, hopelessness, well-being, suicide
Physical Function
Mobility, self-care, strength
Technology platforms
Loneliness in Later Life
Psychotherapy
Home delivered & congregate meals
Cognitive function:
Memory, executive functioning, dementia
Physical Health:
Perceived health, physical illness, longevity
Group exercise
Friendly calling
Robotic & real pets

Peer companionship & friendly calling

Friendly calling during the pandemic (Kahlon et al., 2021):

- **Population:** Older adults receiving Meals on Wheels during the pandemic
- **Design:** Randomized controlled trial
- **Intervention:** 4-weeks of empathy-oriented friendly calls (or no intervention)
- **Results:** reduced loneliness (medium effect size), depressive symptoms, and anxiety symptoms.

Face-to-face peer companionship (Conwell, Van Orden, et al. 2020):

- **Population:** Lonely older adults
- **Design:** Randomized controlled trial
- **Intervention:** one year of peer companionship (or no intervention)
- **Results:** reduced depressive and anxiety symptoms and feeling like a burden, but no effect on loneliness/belonging.

Take away: these programs likely provide benefit to many older adults willing to participate but unclear under what conditions these programs are beneficial; see also ‘befriending’ literature

Resources :

- The Institute on Aging’s 24-hour toll-free Friendship Line: 1-800-971-0016
- AARP’s Connect2Affect website offers additional ideas and resources: https://connect2affect.org

References

- Conwell, Y., et al. (2020). ”Peer companionship for mental health of older adults in primary care: A pragmatic, non-blinded, parallel-group, randomized controlled trial. The American Journal of Geriatric Psychiatry.
- Kahlon, M. K., et al. (2021). "Effect of Layperson-Delivered, Empathy-Focused Program of Telephone Calls on Loneliness, Depression, and Anxiety Among Adults During the COVID-19 Pandemic: A Randomized Clinical Trial." JAMA Psychiatry. 10.1001/jamapsychiatry.2021.0113

Mindfulness training

Smartphone-based mindfulness training (Creswell et al., 2012):

- **Population:** Healthy adults age 55-85 (mostly women)
- **Design:** Randomized controlled trial
- **Intervention:** 8 weeks of group Mindfulness-Based Stress Reduction with weekly 2 hour group sessions, day long retreat, 30 mins daily at home practice (or wait list control)
- **Results:** reduced loneliness after the program.

Smartphone-based mindfulness training (Lindsay et al., 2019):

- **Population:** Young and middle aged adults with elevated stress (not loneliness)
- **Design:** Randomized controlled trial
- **Intervention:** 14-weeks of daily 20-minute audio lessons via smartphone (or control)
- **Results:** reduced loneliness (by 22%), increased social contact by 2 additional interactions per day and one more person per day.

Take away: mindfulness approaches that teach acceptance and self-compassion reduce psychological distress and may reduce loneliness in older adults.

Resources:

Headspace app: (including loving kindness meditation): http://headspace.com
Tara Brach, PhD, Guided Meditation: https://www.tarabrach.com/meditation-times-of-pandemic/

Mindfulness references

Creswell, D. J., et al. (2012). "Mindfulness-Based Stress Reduction Training Reduces Loneliness and Pro-Inflammatory Gene Expression in Older Adults: A Small Randomized Controlled Trial." Brain, behavior, and immunity. Link to download: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3635809/

Lindsay, E. K., et al. (2019). "Mindfulness training reduces loneliness and increases social contact in a randomized controlled trial." Proc Natl Acad Sci U S A 116(9): 3488-3493. Link to download: https://www.pnas.org/content/116/9/3488

Behavioral Psychotherapy

Tele-delivered behavioral activation for older adults (Choi et al., 2020; Pepin et al., 2020):

- **Population:** Lonely older adults receiving Meals on Wheels
- **Design:** Randomized controlled trial
- **Intervention:** 5 weekly video sessions of lay-coach behavioral activation focused on social activity (or friendly contacts control)
- **Results:** reduced loneliness, increased satisfaction with social support, and increased social interaction at 6 and 12 weeks.

Engage Psychotherapy (Van Orden et al., 2021; Solomonov et al. 2019):

- **Population:** adults 60+ reporting loneliness and/or feeling like a burden
- **Design:** Randomized controlled trial
- **Intervention:** 10 in-home sessions (over approximately 10 weeks) of Social Engage Psychotherapy focused on social engagement (or no intervention)
- **Results:** reduced depressive symptoms and increased social-emotional quality of life at 10-week follow-up (no effect on loneliness or belonging). Solomonov: social activities in Engage for depression were most effective type of activities (versus pleasant or physical).

Take away: Brief, behavioral therapies hold promise in reducing social isolation & loneliness.

Resources on Connections Planning:

- YouTube video: https://www.urmc.rochester.edu/labs/van-orden.aspx
- Handouts: https://www.eenet.ca/resource/social-connection-isolated-older-adults

References

- Choi, N. G., et al. (2020). "Improving Social Connectedness for Homebound Older Adults: Randomized Controlled Trial of Tele-Delivered Behavioral Activation Versus Tele-Delivered Friendly Visits." Am J Geriatr Psychiatry 28(7): 698-708. https://doi.org/10.1016/j.jagp.2020.02.008
- Solomonov, N., et al. (2019). "Engagement in Socially and Interpersonally Rewarding Activities as a Predictor of Outcome in "Engage" Behavioral Activation Therapy for Late-Life Depression." Am J Geriatr Psychiatry.
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Group exercise & health promotion programs

Community-based group health programs for older adults: Leveraging Exercise to Age in Place (LEAP) Study (Mays et al., 2020)

- Population: age 50+, referred by provider or self-referred, loneliness not inclusion criteria
- Design: non-randomized clinical trial
- Intervention: Meeting with program coordinator to select an evidence-based program commonly offered by social service agencies: Tai Chi for Arthritis, EnhanceFitness, the Arthritis Foundation Exercise Program, or the Healthier Living Workshop.
- Results: Decreased loneliness and increased social support at 6 month follow-up

¡HOLA, Amigos! group walking program for Hispanic/Latino older adults (Jimenez et al., 2017):

- Population: Older adult (60+) latinos with subthreshold depression/anxiety symptoms
- Design: Randomized controlled trial
- Intervention: ¡HOLA, Amigos! = The Happy Older Latinos are Active (HOLA) program, community health worker face-to-face meeting, then group walk (45 mins) 3x's week for 16 weeks or information control.
- Results: reduced loneliness at end of the program.

Take away: group exercise & health promotion hold promise, especially as they are non-stigmatizing

Resources :

- ¡HOLA, Amigos! Podcast interview with Dr. Jimenez: https://www.ajgponline.org/doi/story/10.1016/audio.2018.03.07.6716

References

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Pets: robotic and real

Robotic & real pets in long-term care (Robinson et al., 2013):

- **Population:** older adults in long-term care
- **Design:** randomized controlled trial
- **Intervention:** robotic pet group 2x's week for 12 weeks or care-as-usual; also observed behavior with real dog
- **Results:** reduced loneliness after 12-weeks; increased engagement in group with robotic pet versus live dog

Robotic pets for older adults (Pu et al., 2018)

- **Population:** older adults, including those with dementia
- **Design:** systematic review of randomized trials and meta-analysis
- **Intervention:** social robots – psychological, physiological, quality of life, medication useage
- **Results:** 11 studies, effects on agitation, anxiety, and quality of life, potentially increased social engagement and reduced loneliness and less medication use.

Take away: pets (both robotic and real) hold promise.

Resources :

- Joy for All Pets: https://joyforall.com/
- Gerontological Society of America, resources on Human Animal Interaction: https://www.geron.org/programs-services/alliances-and-multi-stakeholder-collaborations/human-animal-interaction-and-healthy-aging

References

- Robinson, H., et al. (2013). "The psychosocial effects of a companion robot: a randomized controlled trial." J Am Med Dir Assoc 14(9): 661-667.

- Pu, L., et al. (2019). "The Effectiveness of Social Robots for Older Adults: A Systematic Review and Meta-Analysis of Randomized Controlled Studies." Gerontologist 59(1): e37-e51.

Technology platforms

Personalized reminder information & social management system (PRISM; Czaja et al., 2017):

- **Population:** community-dwelling older adults at risk for social isolation (minimal computer/Internet use, not employed/volunteering more than 5 hr/week, or more than 10 hr/week at senior centers/ formal organizations.
- **Design:** Multi-site randomized controlled trial
- **Intervention:** PRISM vs. binder control for 12-months. PRISM = computer with internet; an annotated resource guide, a dynamic classroom feature, a calendar, a photo feature, E-mail (PRISM buddy email connections), games, and online help; 3 home visits for training & check-in calls in both groups.
- **Results:** the PRISM group reported significantly less loneliness and increased perceived social support and well-being at 6 months, not 12 months.

Technology interventions for loneliness in older adults (Choi, Kong, & Jung, 2012):

- **Population:** older adults, any living situation
- **Design:** Meta-analysis of clinical trials
- **Intervention:** intervention that involved computer or Internet use for psychosocial outcomes
- **Results:** Significant variation in outcomes of studies, but significant effect on loneliness.

Take away: these programs likely provide benefit to many older adults but it's not clear which platforms are effective and accessible.

Resources :

- Zoom website tutorial on joining a meeting: https://support.zoom.us/hc/en-us/articles/201362193-How-Do-I-Join-A-Meeting-
- AARP online article and tutorial video: https://www.aarp.org/home-family/personal-technology/info-2020/how-to-use-zoom.html
- Senior Planet pdf tutorial on zoom and practice online events: https://seniorplanet.org/get-involved/online/

References

- Czaja, S. J., et al. (2017). "Improving Social Support for Older Adults Through Technology: Findings From the PRISM Randomized Controlled Trial." Gerontologist.
- Choi, M., Kong, S., & Jung, D. (2012). Computer and internet interventions for loneliness and depression in older adults: A meta-analysis. Healthcare Informatics Research, 18, 191–198. doi:10.4258/hir.2012.18.3.191

Services supported by the Older Americans Act

Home delivered meals

- Improvements in well-being & loneliness after two months of Meals on Wheels (program evaluation, no control group), Wright et al. (2015)
- Qualitative analysis of Meals on Wheels drivers and program staff highlighted social support component (Thomas et al., 2020).
- Review of outcomes indicates a need for more study on psychosocial benefits (Campbell et al., 2015)

Geriatric care management

- Most research on programs in healthcare (versus social service) settings
- Counsell et al. (2007) found improved social functioning with 2 years of home-based care management via primary care for low income older adults (RCT)

Senior centers & congregate meals: more research and empirical program evaluation needed on psychosocial benefits.

Volunteering: Strong evidence from numerous studies and program evaluations: improved physical health, physical functioning, cognitive functioning, mental health. Benefits for isolation & loneliness unclear.

Take away: these programs provide benefit to many older adults; controlled studies could help increase funding for these programs, including benefits of connecting primary care and aging services.

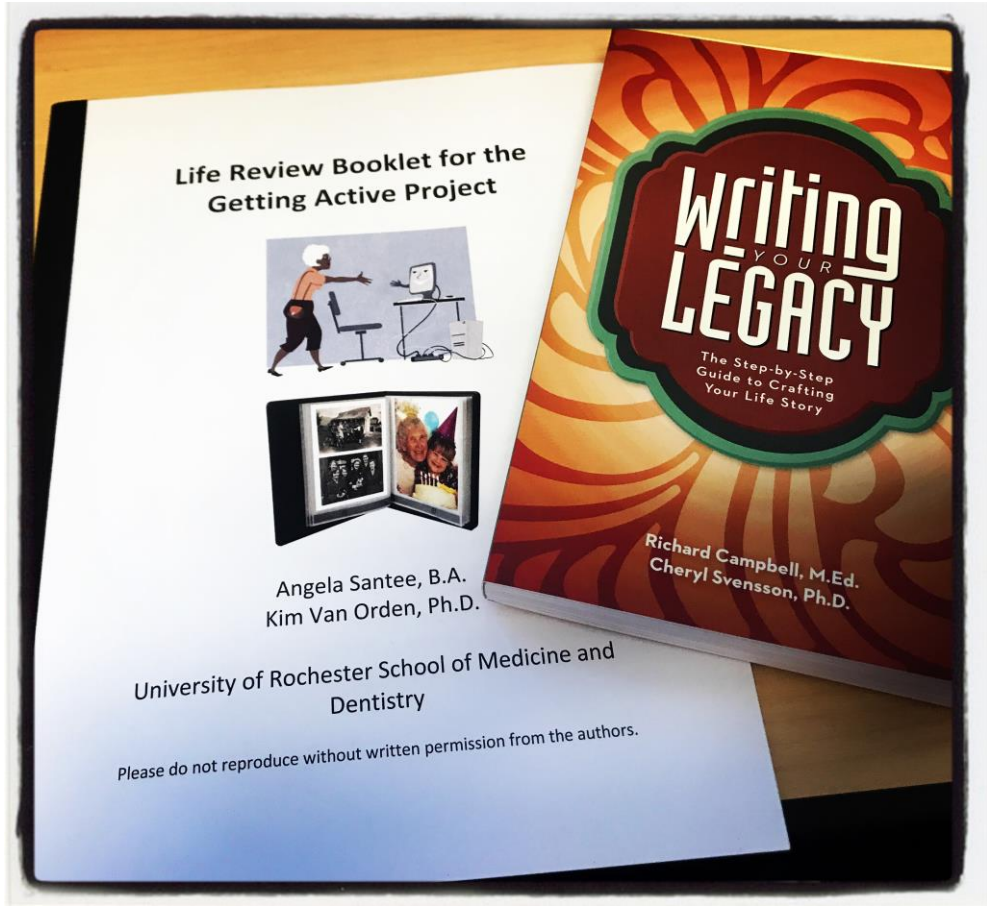
References

- Wright, L., et al. (2015). "The Impact of a Home-Delivered Meal Program on Nutritional Risk, Dietary Intake, Food Security, Loneliness, and Social Well-Being." J Nutr Gerontol Geriatr 34(2): 218-227.
- Campbell, A. D., et al. (2015). "Does Participation in Home-Delivered Meals Programs Improve Outcomes for Older Adults? Results of a Systematic Review." J Nutr Gerontol Geriatr 34(2): 124-167.
- Counsell, S. R., et al. (2007). "Geriatric care management for low-income seniors: a randomized controlled trial." JAMA 298(22): 2623-2633.

The HOPE Project: Helping Older People Engage

A randomized trial to reduce loneliness in later life (R01AG054457, Van Orden, PI)

60+
Lonely



N=150

N=150

Poll question #2:

Are there are evidence-based interventions for loneliness and social isolation?

Yes, research studies and program evaluations identify evidence-based programs.

No, we do not know enough to state that any program is evidence-based.

We do not know enough to state that any specific program is evidence-based.

- Absence of replication and/or standardized programs.
- Mechanisms unclear (group versus individual; maintenance over time).
- Most studies do not enroll lonely or isolated individuals.
- Unclear if findings generalize to the larger population of older adults outside a research study, or in less controlled settings.
- Will older adults most at risk complete these programs outside of research studies?
  - Older adults report being less likely to engage in interventions framed as targeting loneliness or being specifically targeted to older adults (Kharicha et al., 2017).
    - Kharicha, K., et al. (2017). "What do older people experiencing loneliness think about primary care or community based interventions to reduce loneliness? A qualitative study in England." Health Soc Care Community.
  - Community providers: Call for greater research attention to understanding the relevance and acceptability of services and interventions to older adults, with a goal of improving utilization.
    - Sabir M, Wethington E, Breckman R, Meador R, Reid MC, Pillemer K. A Community-Based Participatory Critique of Social Isolation Intervention Research for Community-Dwelling Older Adults. J Appl Gerontol. 2009;28(2):218-234.

Community provider perspectives
Sabir et al., 2009

Many studies focus on older adults who are ambulatory and able to attend community events and programs vs those who are homebound and isolated.

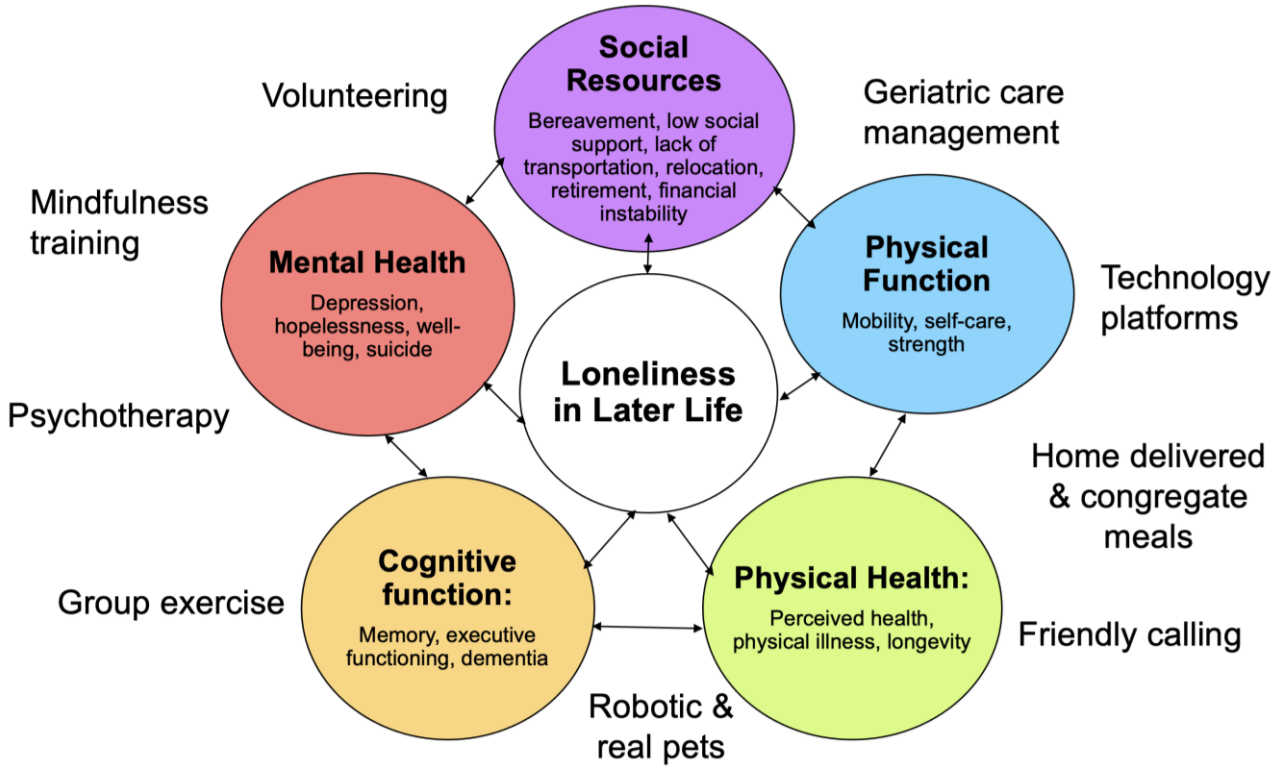
Interventions that allow individuals to develop relationships that can continue past the end of the program and that involve interaction with one's community will likely be most effective at improving social connectedness.

The need for a broader view of the problem of social connectedness, taking into account individual contexts or needs and multiple components of social connectedness vs. targeting a single specific component,

Call for greater research attention to understanding the relevance and acceptability of services and interventions to older adults, with a goal of improving utilization.

Sabir M, Wethington E, Breckman R, Meador R, Reid MC, Pillemer K. A Community-Based Participatory Critique of Social Isolation Intervention Research for Community-Dwelling Older Adults. J Appl Gerontol. 2009;28(2):218-234.

Part 2: Pulling it All Together:
What we know and don't know (yet)



1. We know that social connection matters for health, well-being, and longevity in later life.
2. We know that social isolation and loneliness have many causes and consequences.
3. We know that behavioral programs can reduce loneliness and social isolation.
4. We don't know yet which programs are most effective, for whom, in what circumstances, or why they work.
5. We hope to learn how to tailor intervention strategies to address individualized contributors to loneliness and isolation.

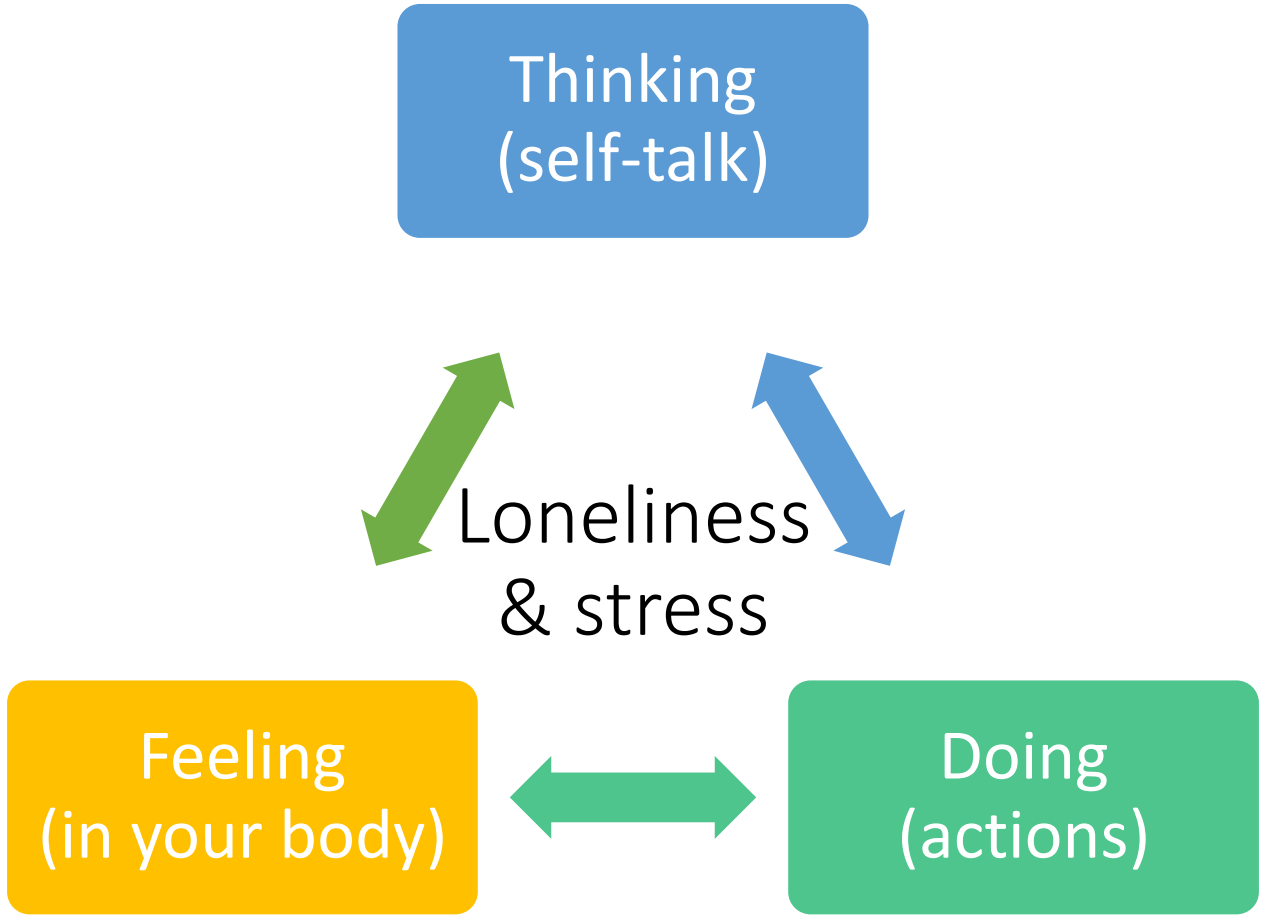
Part 3. Practical strategies

Creating a ‘Connections’ Plan
An evidence-informed brief intervention

- Analogous to Safety Planning for suicidal behavior
  - Can be done in a brief (e.g., 30 minute) session
  - Can be standalone or part of psychotherapy (and evolve)
- Slightly more intensive than simple recommendation for ways to connect
  - Being intentional about connections may be a new concept
  - Motivational barriers
- Applying basic CBT principles to a brief intervention for social connectedness
  - Few interventions with efficacy in increasing social connections and reducing loneliness.

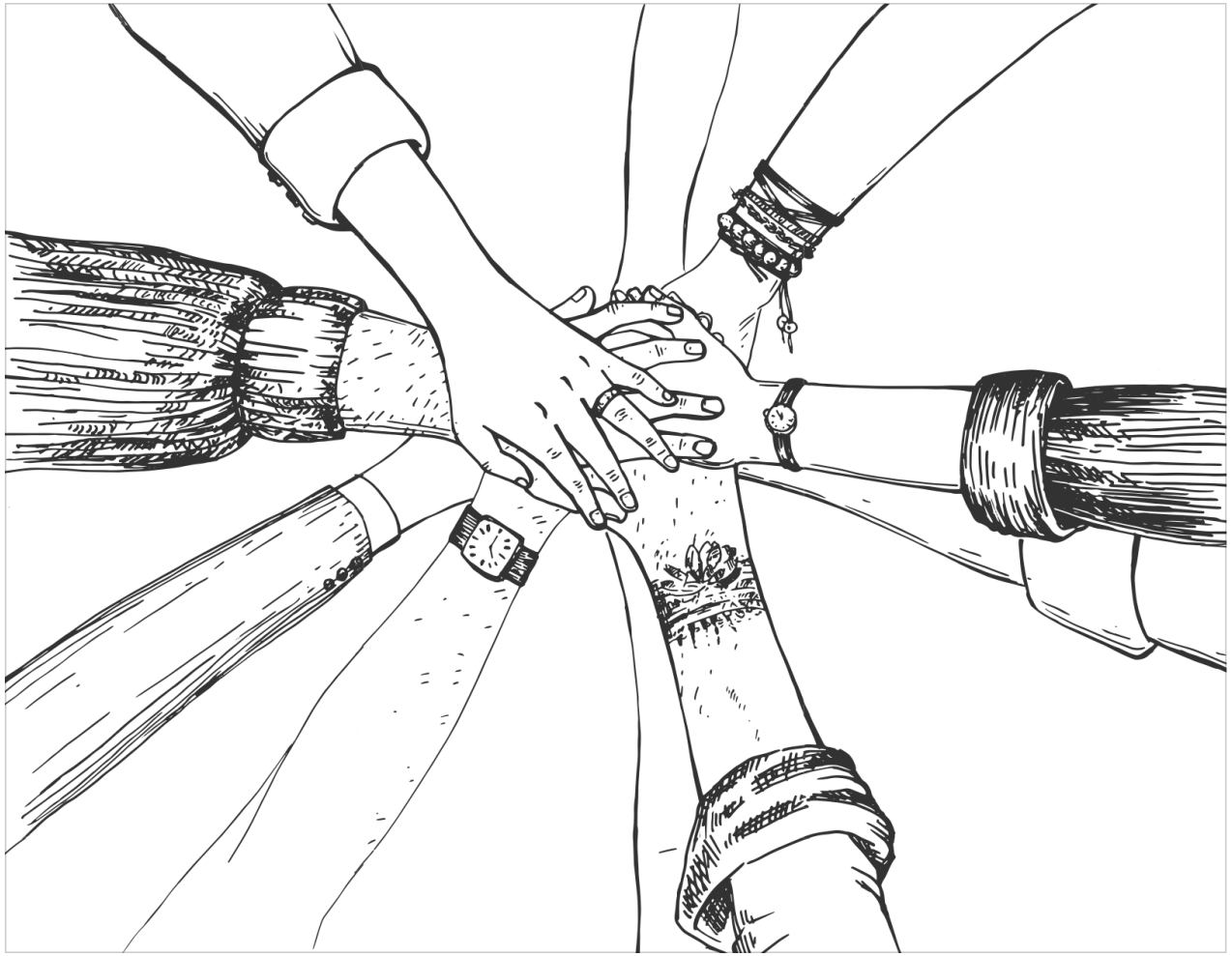
Cognitive Behavioral Therapy (CBT)

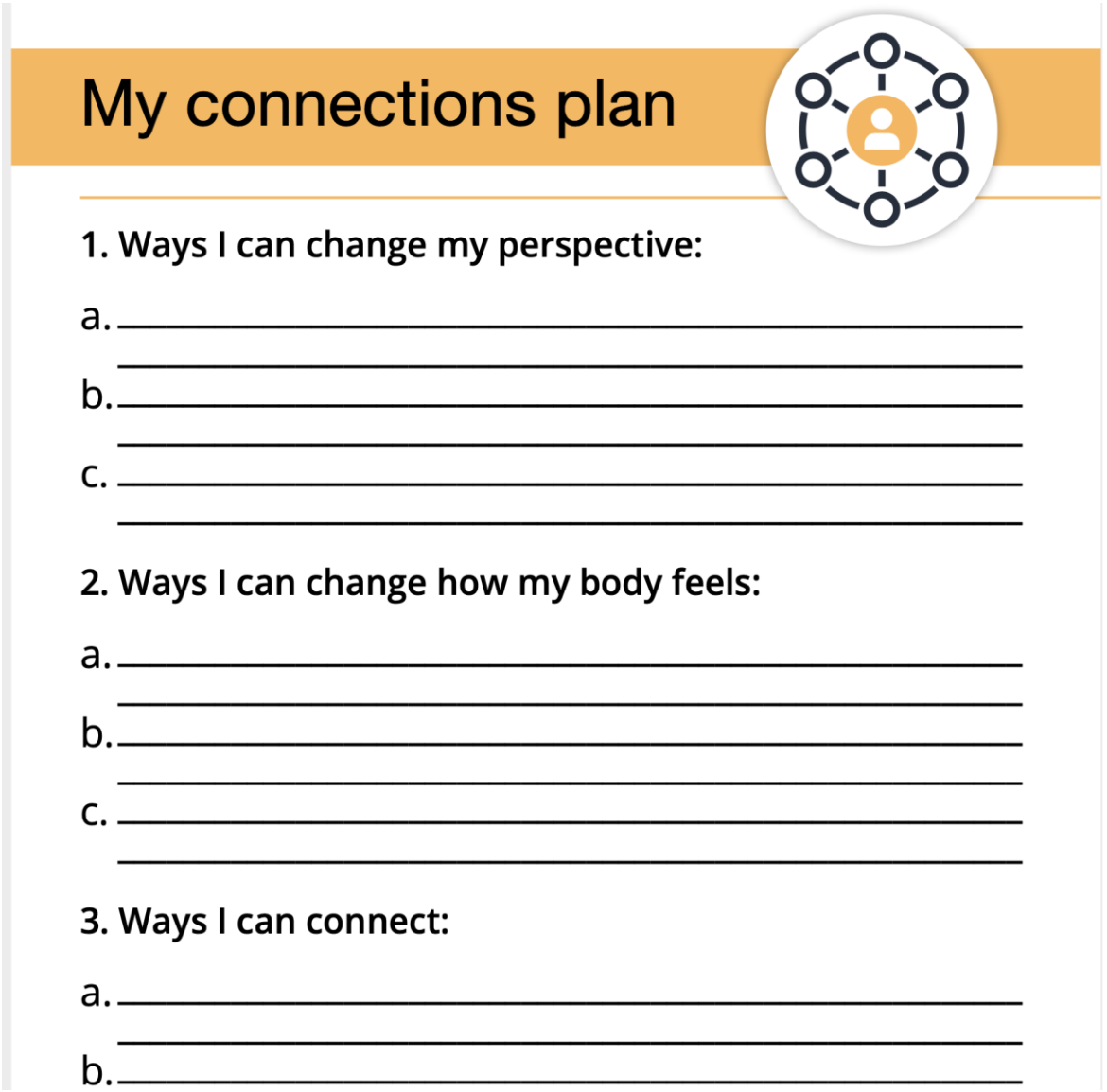
Applied to social isolation



Clinician's primary task is assessment of social connectedness

- Assessment goals are to determine:
  - What is causing feelings of loneliness and isolation
  - What the client values socially
  - What barriers exist that make it difficult to find new ways to connect.





Worksheet to create a Connections Plan

The ‘cognitive model’ applied to connectedness:

Psychoeducation

Matching thoughts to emotions exercise

This exercise is a helpful way to discuss the relationship between thoughts and feelings. It shows how different interpretations of being alone can lead to different thoughts and emotions.

Thoughts	Emotions
What if I get sick and there’s no one to help me?	Guilt
I will become a burden on my son.	Fear
No one cares about me.	Sadness

Strategies to change your perspective

Ask

Ask yourself:

- "How can I view this situation from a different perspective."
- "How would someone I think highly of view this situation?"
- Remind yourself, "Don't believe everything you think!"

Practice

Practice mindfulness or a spiritual practice.

- Headspace.com
- https://www.tarabrach.com/meditation-times-of-pandemic/

Write down

Write down your thoughts:

- List reasons that support the thought and reasons that challenge that thought.
- For example, a reason to challenge the thought "no one cares about me" could be "friends and family are protecting my health by not visiting".

Strategies to change your body sensations

Soothe all five senses

Listen to music, smell freshly baked cookies, pet your dog/cat, look at artwork, taste your favorite food, step outside

Practice calming activities

Mindful breathing

Muscle relaxation

Imagery

Change your temperature

Warm up by taking a bath or sipping warm tea. Cool down by splashing cold water on your face or holding an ice cube.

Doing: connecting with others in new ways

1

Focus on helping others

- Volunteer remotely (e.g., write letters to someone living in a nursing home) or take care of a neighbor's pet or plants.

2

Connect with others in safe ways

- Call loved ones, look at photographs or call friendly lines for support.

3

Remind yourself of our shared humanity:

- Connect with nature (e.g., watching birds or looking at flowers), make art or listen to music.

Example 1: Mr. Jones who lives alone at home

- Mr. X is a 74-year-old widowed man who lives alone in an apartment.
  - Mobility issues due to past hip fracture
  - Unable to drive due to vision loss.
- Thinking:
  - “I am being forgotten by my neighbors.” → “My neighbors have not forgotten me. They would appreciate spending time with me, but circumstances out of their control make it difficult to visit.”
- Feeling:
  - When anxious he takes five deep breaths and imagines he is in his childhood home, which is a positive memory for him.
- Doing:
  - Plan to call other members of his church who also live alone to check in.
  - Plan to call his neighbor to learn how to set up video calls.

Ms. Zayas, a Spanish-speaking woman who lives alone

- Ms. Z is a 59-year-old Spanish-speaking woman who lives alone.
  - Born and lived in Puerto Rico until 2017, moved to live near her daughter and grandchildren in the wake of Hurricane Maria.
  - Relies on her daughter for transportation and as her English interpreter.
  - Ms. Z reports feeling increasingly anxious and isolated. She feels worried for her family in Puerto Rico and feels trapped in her own home.
- Thinking:
  - "I'm a burden on my family." → "My family wants to take care of me because they love and need me."
- Feeling:
  - Anxiety about lack of information about home and current pandemic: listens to favorite music from childhood to feel calm and safe.
- Doing:
  - Lack of activities with others who speak Spanish (due to social distancing): plans regular calls with other members from the senior center and her family in Puerto Rico.

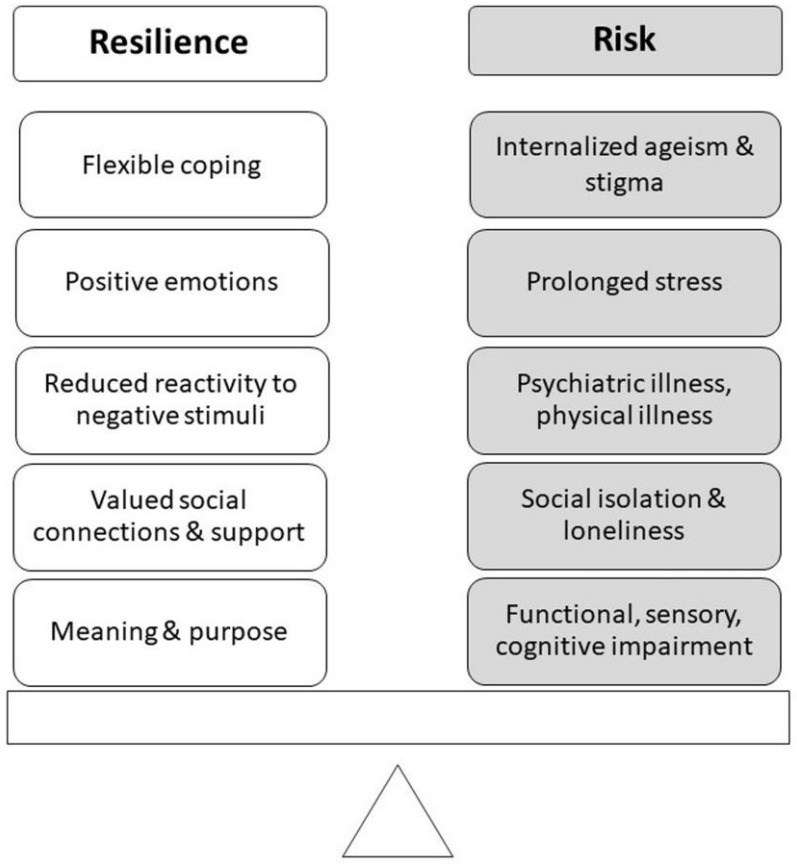
Mr. Yang, who lives in a nursing home

- Mr. Yang is a 77-year-old, Chinese male; admitted to a nursing home 6 months ago due to frequent falls & difficulties with ADL's.
  - Wife of 45 years resides in their home and would visit several times a week before the pandemic; they used to enjoy cooking together and going on walks.
  - Spends much of his time watching TV in his room or sleeping.
  - Difficulty following conversations over the phone.
- Collaborative process with behavioral health clinician, recreation therapist, social worker.
  - Video conferencing
  - Scrapbook with recreation therapist
  - Poster for staff

Resources & more information about Connections Planning

- CAMH information and handouts:
  - https://www.eenet.ca/resource/social-connection-isolated-older-adults
- Article in *The American Journal of Geriatric Psychiatry* (free download):
  - https://www.ajgponline.org/article/S1064-7481(20)30333-X/fulltext
- Video, Connect During Covid:
  - https://www.youtube.com/watch?v=0WL7hLz45p8
- Veterans Administration Connections Planning manual:
  - https://www.mirecc.va.gov/visn5/training/connection_plans.asp

In closing: the bigger picture



Lutz & Van Orden: *Med Clinics of NA* 104:843-854, 2020

Stay connected!

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- HOPE Lab: www.urmc.rochester.edu/labs/van-orden