NCPD 2.0 contact hours

By Elizabeth M. Long

Faith Community Nursing: Identifying and Combating Social Isolation

AND LONELINESS IN OLDER ADULTS

ABSTRACT: *The number of older adults worldwide is growing; the incidence of social isolation and loneliness among this population is also increasing. Social isolation and loneliness can have significant physical, mental, and spiritual impacts. Faith community nurses are in an optimal position to identify and intervene to help faith communities reduce the social isolation and loneliness among community-dwelling older adults. Risk factors and tools to identify both circumstances are discussed along with interventions and a case study.*

KEY WORDS: *faith community nursing, loneliness, nursing, older adults, social isolation*

Elizabeth M. Long, DNP, RN, GNP-BC, CNS, CNE, FCN, is an assistant professor of nursing at Lamar University, Beaumont, TX, a gerontological nurse practitioner, and a faith community nurse. Her current projects include music and memory, dementia training, and research into ways congregations can combat isolation.

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The human body uses many parts to be able to function as one unit. Each part on its own, for example a knee, requires the other parts to work. It is the same within a faith community. The apostle Paul related, "For just as each of us has one body with many members, and these members do not all have the same function, so in Christ we, though many, form one body, and each member belongs to all the others" (Romans 12:4-5, NIV). We, as Christians, are to function as a unified body embracing all our members, utilizing all our parts, young and old. Jesus calls us to be in relationship with others, each of whom has a unique function. However, the older segment of the United States population often is overlooked or marginalized.

Knowledge of issues facing the aging population, which contributes to social isolation and loneliness, can be a first step in a meaningful opportunity to care for these people. Older adults still have much to offer, as illustrated in Job 12:12: "Is not wisdom found among the aged? Does not life bring understanding?" (NIV). With the COVID-19 pandemic, loneliness and social isolation have intensified. Faith community nurses can be a crucial link to older adults who are socially isolated and experiencing loneliness.

TRENDS IN THE AGING POPULATION

The older adult population is growing globally. The United States Census Bureau predicts that by 2030, this group will increase to 21% of the U.S. population or 73.1 million persons. The number of the oldest old (85 years and older) is expected to grow by more than 200% by 2060 (Vespa et al., 2020).

Trends in the older adult population include having fewer children and living in a mobile society; often parents and their adult children do not live in close proximity to one another (Scommengna et al., 2018). In recent years, older adults are spending more time as widows or widowers and have fewer siblings than older adults have had in the past (Kasper & Freedman, 2019; Stocker et al., 2020). The divorce rate at a later age also is more common (Brown et al., 2018). For the first time, according to the U.S. Census Bureau, older adults are projected to outnumber children by the year 2034 (Vespa et al., 2020).

SOCIAL ISOLATION AND LONELINESS

Social isolation is a measurable state wherein the number of connections or frequency of contact with one's connections is small. This is a major, prevalent issue facing older adults; an estimated 1 in 5 adults is socially isolated (Health Resources & Services Administration, 2019). According to the *National Health and Aging Trends Study,* 7.7 million (24%) of community-dwelling older adults reported feeling socially isolated (Kasper & Freedman, 2019). In the online

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National Poll on Healthy Aging, a nationally representative sample of 2,051 adults aged 50 to 80 answered a wide range of questions. Results from the poll suggested 34% of adults in this age group reported feeling a lack of companionship and 27% reported feeling socially isolated (University of Michigan, 2019).

Although often associated with social isolation, loneliness is a separate phenomenon. Loneliness historically has been defined as the subjective psychological discomfort people experience when their network of social relationships is significantly deficient in either quality or quantity (Perlman & Peplau, 1998). With loneliness, there may be a discrepancy between the number of desired and actual relationships. In 2018, the American Association of Retired Persons (AARP) conducted a survey of adults aged 45 and older. The results showed that 1 in 3 adults reported being lonely (AARP, 2018). Evidence suggests loneliness may be even greater in those with a lower socioeconomic status (AARP, 2018). Like social isolation, loneliness does not discriminate; every older adult can develop loneliness.

The National Poll on Healthy Aging results indicated that feelings of loneliness showed up most in people aged 50 to 80 who also reported experiencing health issues and unhealthy habits. In contrast, people who said they ate healthy diets, exercised, got enough sleep, or didn't use tobacco were less likely to report feelings of loneliness (University of Michigan, 2019). More than a quarter of respondents indicated they had social contact only once a week or less with family members they did not live with, or with friends and neighbors (University of Michigan, 2019). This is key information for the faith community and faith community nurses (FCNs), indicating the importance of proactively reaching out to those in the community who may be at risk of feeling isolated and disconnected.

HEALTH IMPACTS OF LONELINESS AND SOCIAL ISOLATION

Social isolation and loneliness can profoundly impact physical health. Older adults who are lonely and socially isolated are at greater risk for functional decline and death (Singer, 2018). Data suggest these effects of social isolation/loneliness: decreased quality of life, poor health outcomes, an increased risk of premature mortality, physical and functional disability, frailty, increased falls, and an increased number and length of hospitalizations (Flowers et al., 2017; Kasper & Freedman, 2019; National Institute on Aging, 2019; Shankar et al., 2017). Chronically lonely older adults reported utilizing isolated activities to cope, such as eating, watching television, and surfing the Internet. However, those who seldom felt lonely were more likely to talk with a friend or go out with family when feelings of loneliness occurred (AARP, 2018; University of Michigan, 2019).

Social isolation and loneliness also significantly affect psychological health. Mental illness contributes to social isolation, and social isolation is a risk factor for mental illness. Common

SIDEBAR: CASE STUDY

Violet is an 88-year-old woman who has participated in her local church since she was a small child. She was married in this same church, and she and her husband attended together until his sudden death 10 years ago.

Up until 6 months ago, Violet was able to drive to church services on Sunday, the Women's Mission Group monthly meetings, and a weekly Bible study. Now she is no longer able to drive. She has one daughter who has never married and lives out of state. Violet has no living siblings, nieces or nephews, or grandchildren.

At the weekly church staff meeting, it was noted Violet has not been to services, mission meetings, or Bible study in the past 2 months. The FCN contacted Violet and discovered the above history and that the woman who was previously driving Violet to church activities had moved to a retirement community in another city. Violet did not want to bother anyone to ask for a ride, so she has not been attending. During the telephone conversation with the FCN, Violet stated that she "misses going to my church," and that "it was a big part of my life for a long time."

The FCN contacted the church's health ministry team who created a plan to provide transportation for Violet. A team member contacted the leader of the Women's Mission Group who agreed to pick up Violet for the monthly meetings. If this leader was unable at any time to provide transportation, she agreed to contact one of the other group members.

Next, the FCN attended the weekly Bible study and spoke to the group about Violet's situation. Once the group members were aware of Violet's need, they devised a plan in which each group member would take a week and bring Violet to the Bible study as well as to church on Sunday. The intervention at the initiative of the FCN to arrange transportation for Violet led to a working plan for Violet to be able to attend Bible study and church. This intervention also provided the opportunity for other faith community members to serve. Beginning the next Sunday, Violet was picked up at her home by a fellow Bible study member and also taken to church in time for Sunday school and the worship service.

issues for individuals who are lonely or isolated include cognitive decline, psychological distress, mental health issues, neglect and exploitation, and worsening dementia. In addition, socially isolated and lonely older adults have a higher risk of death from suicide (Alzheimer's Association, 2018; Sutin et al., 2020; Werner-Seidler et al., 2017).

Spiritual health and connectedness also are influenced by social isolation and loneliness. According to the Pew Research Center (2017), 84% of humans value some form of spirituality or religion. Spiritual care needs vary, but examples may include prayer, emotional support, relationships with others, and religious activities (Christman & Mueller, 2017). One FCN reported, "Recently we had a parishioner who moved to Arizona and [then] lost his wife. [He] feels like nobody cares in his new community. He reached out to us because he stopped going to church and feels all alone. This [combatting isolation and loneliness] is a very much needed topic because when I was in my car accident, I lost all my friends and co-workers; it was really hard to get better" (K. Mackey, personal communication).

Another FCN reported utilizing a friendly visit program within her congregation. She stated, "Spiritual care was accomplished first by showing up, next by being fully present, following [congregants'] lead in conversation and activity, and offering to pray when appropriate" (B. Baklarz, personal communication). These examples demonstrate the value and importance of relationship and community.

Janzen et al. (2019) reported studies on spirituality have been correlated with well-being, ability to recover from illness, and coping. Encouraging data suggest spiritual resources can buffer the effects of depression, and involvement in religious institutions may protect against loneliness in later life. Religious activities can be effective in preventing or improving depression (Ali et al., 2015; Charles & Wolfer, 2018; Parson, 2019).

ROLE OF THE FAITH COMMUNITY NURSE

After identifying risk or experience of social isolation and/or loneliness in older adults, FCNs can intervene by promoting connectedness. Research suggests that few adults say a health professional has asked them about social isolation (Perissinotto et al., 2019). The FCN should be asking questions and listening attentively as an advocate for faith community members who are at risk of isolation or loneliness.

Identify older adults who are socially isolated or experiencing loneliness within their faith community by recognizing potential risk factors. Interestingly, older adults in rural areas are more at risk for social isolation, but those in an urban setting are more likely to be lonely (Kaye & Singer, 2018). Correlation of the risk factors to those within the faith community provides the first step in identifying the need. Ideally, the faith community could intervene with those at risk before elders develop isolation or loneliness.

Risk factors for social isolation. Evidence points to some risk factors for social isolation in the older adult population (AARP, 2018; Dejulio et al., 2018; Kaye & Singer, 2018). These include living alone, having a mobility or sensory impairment, experiencing a recent major life transition or loss, low income or limited financial resources, being a caregiver for someone with a serious condition, and psychological or cognitive challenges (AARP, 2018; Dejulio et al., 2018; Kaye & Singer, 2018). Other risk factors include being age 80 or older; having inadequate social support; living in a rural or inaccessible neighborhood; transportation challenges; language barriers; and ethnic, sexual orientation, or gender identity barriers (University of Michigan, 2019). Although these are all risk factors, social isolation does not discriminate; we all have the potential to become socially isolated.

Risk factors for loneliness. Loneliness is not usually caused by a single event and affects everyone, thus presenting multiple opportunities for

the FCN to intervene. An individual's social network and physical isolation are top predictors, but depression, living in an urban area, anxiety, and overall health are also contributing factors. In individuals with increased loneliness, surveys reported findings of physical isolation, a diagnosis of depression or anxiety, living in an urban environment, and increased use of technology for communication (AARP, 2018).

In contrast, older persons with less loneliness have a robust social network and weekly or more frequent contact with siblings or friends. In addition, they reported sleeping more hours per night and experiencing good health as well as more frequent engagement in hobbies and clubs, volunteering, and religious activities. Interestingly, a significant number of those who had one or more children living with them were more likely to say they lacked companionship (AARP, 2018). Loneliness is often related to a specific cause such as death of a loved one, physical problems, or isolation. It also occurs more often in women than men. Studies suggest that loneliness has approximately the same incidence across race and ethnicity (AARP, 2018; Kasper & Freedman, 2019; University of Michigan, 2019).

Faith community nurses can intervene to overcome isolation and loneliness by promoting connectedness.

TOOLS TO IDENTIFY SOCIAL ISOLATION OR LONELINESS

Social isolation is tied to connections or relationships. Potential relationships include those with family, friends, and in the community. All of these connections should be included when evaluating how isolated someone may be. The AARP Foundation and several healthcare organizations developed the *Connect 2 Affect* tool to help identify social isolation. Available online at https://connect2affect.org/about-us/, the assessment can be completed by an individual or by someone who is concerned that another may be suffering social isolation. The 12 questions are written in a yes/no format. Some question themes include seeing or talking to family members once a week, transportation, meaningful contributions, and participation in activities. Results to the questions describe the risk for isolation as low, moderate, or high. Online resources are also provided (AARP, 2019). This tool can aid FCNs to identify those who may be suffering social isolation. The FCN can utilize this tool individually or provide it on websites, in bulletins, and through other faith community communications so others can complete the tool themselves or for those who they feel are at risk.

To assess the degree of subjective loneliness, the Revised-UCLA Loneliness Scale is a validated and reliable tool (Elphinstone, 2017). The scale looks at three dimensions: relational connectedness, social connectedness, and self-perceived isolation. The 20 questions on the scale are in a Likert response format with the respondent indicating never, rarely, sometimes, or often to each question. This tool can be completed by an individual or by a reviewer asking the questions. There is also a shortened version with just three questions (Elphinstone, 2017; Hughes et al., 2004).

PROMOTING CONNECTEDNESS

Ways to promote connectedness and relationship with individuals vary. Individual connection methods include in-person visits which could include offering communion, delivery of church bulletins and other information, or simply social visits. One faith community set up a *Compassionate Visitation Program*. This successful program recruited and trained visitors, established a method to assess the homebound members and their environment, and developed a recordkeeping system of the visits. Meaningful activities were planned for the visits such as indoor gardening, reminiscence boxes, and a visitor book (Emblen, 2016).

Telephone ministries can promote relationship. In a survey about telephone use, Petersen et al. (2016) reported that the data suggested loneliness was more closely tied to incoming rather than outgoing calls. In short, older adults are potentially less lonely when others call them routinely. Some problems with telephone use are hearing loss, arthritis, and visual impairments. Special phones can be purchased for each of these concerns. A telephone ministry with designated persons calling homebound members a few times a week to visit and or check up could also allow the homebound faith community member to participate by telephoning other members who need to be connected.

Technology holds promise to help reduce loneliness and social isolation, but it is not a substitute for human interaction. An opportunity exists for the FCN to provide education regarding online activities, tools, and applications that facilitate staying in touch with others; lonely people may have a greater incentive to learn how to use these tools. Social media use has more than tripled since 2010, with 42% of midlife and older adults using social media daily compared with 13% in 2010 (AARP, 2018). In one technological social engagement program in Canada (Botner, 2018), a virtual

Web Resources

- **AARP Foundation: Connect2Affect**
  https://connect2affect.org
- **Campaign to End Loneliness**
  https://www.campaigntoendloneliness.org/resources-2/
- **Health Resources & Services Administration**
  https://www.hrsa.gov/enews/past-issues/2019/january-17/loneliness-epidemic

learning program for older adults was set up to engage senior citizens. The program provided interactive live lectures, a video library, and live discussion groups. The study revealed that online interactive classes decreased feelings of isolation and disconnection in the group studied. The program operators have plans for online social games such as bridge and rummy (Botner, 2018).

A key to providing opportunities to engage socially isolated or lonely adults is to provide opportunities that have meaning to the individuals. Social activities, support groups, and meetings geared around hobbies or Bible study may be effective ways to promote connectedness. Volunteer activities, religious activities, reminiscence groups, and exercise groups have been shown to promote well-being (Crittenden, 2018; Doka, 2018; O'Rourke et al., 2018). Studies suggest interaction with animals and pets also can decrease the sense of isolation and loneliness (O'Rourke et al., 2018; Stanley et al., 2014).

Faith community members who have stopped driving can easily become isolated. Studies point to the association between having transportation and experiencing loneliness (Dobbs et al., 2018; Matsuda et al., 2019). Is transportation a simple need the faith community can meet? Transportation can provide access to activities in the church or community and for volunteer opportunities. Receiving help to get to activities at the church can allow an older adult who no longer drives the opportunity to participate, serve, and fellowship with others in the faith community. (See Sidebar: Case Study.)

Respite programming is another effective means to promote connection and relationship within a faith community. Some churches host a program that provides a structured time of service and fellowship for older adults once weekly (Hall, 2016). These adults are socially isolated due to cognitive or physical frailties. The sustained respite program, called OASIS (Older Adults Sharing in Service), gives family caregivers 4 hours of free time weekly while providing their loved one an opportunity to participate in stimulating and productive activities in a loving environment. During OASIS, participants complete service projects, exercise, and participate in activities such as music, puzzles, devotions, games, and cognitive stimulation. Children in the church preschool program also participate with the elders in intergenerational activities (Hall, 2016). This ministry helps to combat loneliness and isolation of both the participants and their caregivers.

Spiritual health and connectedness are influenced by social isolation and loneliness.

CONCLUSION

As FCNs identify those who are at risk for loneliness and social isolation, or those who are already lonely or isolated, significant mental, physical, and spiritual care can be given. Finding a connection for older adults and expanding their networks are attainable goals. With the COVID-19 pandemic, older adults are more at risk for social isolation and loneliness. The FCN can be a powerful agent in the fight against social isolation and loneliness in older adults.

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