Episode: Ethics Talk Videocast Transcript – Social Isolation, Loneliness, and COVID-19

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[bright theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This episode is an audio version of a video interview conducted by the Journal's Editor in Chief, Dr Audiey Kao, with Dr Carla Perissonotto. Dr Perissonotto is an Associate Professor of Medicine at the University of California San Francisco. She joined us to talk about the health consequences of social isolation and loneliness during the COVID-19 pandemic. To watch the full video interview, head to our site, JournalofEthics.org, or visit our YouTube channel.

DR AUDIEY KAO: Good afternoon, Dr Perissinotto. Thank you for being a guest on Ethics Talk today. [music fades out]

DR CARLA PERISSONOTTO: Thanks for having me.

KAO: So, it's estimated that more than 35 million Americans live alone, and the share of households with just one person has risen from less than 17 percent in 1969 to over 28 percent last year. According to the National Academy's report that I just referenced a moment ago, 43 percent of adults age 60 or older in the U.S. reported feeling lonely, and that was before the COVID-19 pandemic. The novel coronavirus has swept the globe at a time when more people are living alone than ever before in human history. Before we delve into the many relational challenges aggravated by this pandemic, can you help our audience understand the distinction between being alone and feeling lonely?

PERISSONOTTO: Absolutely. And I'm so glad we're starting with this question, because there's often a misconception that by being alone, you are automatically lonely. And that is absolutely not the case. I think one way to think about it is being alone, is it a choice and something you desire, or is it something that you're forced into and that is causing distress? So, another way to think about it is that when you're lonely, that is something subjective. So, and it is subjective because there's something missing between the relationships you have and the relationships that you wish you had.

KAO: Yeah.

PERISSONOTTO: And the other thing to think about also is that another term, in addition to just living alone and loneliness, is "social isolation." So, social isolation is, again, they can be related, but it's more about the overall number and types of relationship that someone has. So, these terms can be related and coexist, but one does not mean you have the other. So, it's really good to get those terms straight before we move forward, so thanks for asking that.

KAO: Yeah, no. I think I appreciate you describing the distinction between social isolation and the notion of feeling lonely. I think that's very important. So, in the report that you

served on the committee in drafting, you identified quite a bit of negative impacts of loneliness. So, for example, loneliness has been estimated to be equivalent to smoking 15 cigarettes a day. And loneliness and social isolation are associated with increased risk for chronic conditions, including dementia and cardiovascular diseases. Loneliness has also been linked to a 26 percent increased risk for premature deaths. And among Medicare beneficiaries, social isolation has been estimated to increase health care costs by $6.7 billion a year. Given this data, why has this risk of social isolation and loneliness not drawn the attention that it deserves from health professionals and policymakers? And what can be done to address this gap?

PERISSONOTTO: So, I wish I knew the answer to that question, but I will tell you that that is exactly what we should be asking. And I would say that I think, unfortunately, part of what has driven why we haven't focused on this, is for a long time, a lot of the research on loneliness and isolation was in the social sciences literature and not in the medical literature. And so, unfortunately, there was not a lot of focus in our medical community on these social factors. So, that is one thing about why it hasn't been driven into public health approaches and health care dialogues.

The second thing I would say is that in medicine, we've had a really hard time understanding how to conceptualize social determinants of health and really understanding the magnitude of how they affect health.

KAO: Yeah.

PERISSONOTTO: And in many ways, loneliness and isolation actually fit into this framework of a social determinant. And the reason being is that it is a sociological framework and concept with medical consequences.

The other thing I would say is that one of the things we looked at in the report is how we define loneliness and isolation and how we measure have been variable. And so, when you look at all the literature and all these statistics that you're quoting, it's really hard to make sense of exactly how much causes what and what is the causal pathway, because the literature is varied. However, despite that variety in definitions and measurement, we absolutely know without a doubt that both loneliness and isolation have very large health care impacts, public health impacts, and financial impacts. And so, we now have some better clarity around the data. And it is now within our control to start raising awareness to make some changes.

And I think the timing is right, because there's increased focus on social determinants of health. And as you started this discussion, COVID-19 is making us have to force the reality, force us to view the reality that we're all experiencing some degree of isolation because of the physical distancing we're having to undergo. And we have to think very critically about how this is going to affect all of our lives, our health care systems, and our expenditures.

KAO: Yeah. Can I just ask: you mentioned that a lot of the original or early research on loneliness wasn't covered in the traditional medical literature. How did you become interested in this topic?

PERISSONOTTO: Ha, ha. Because I tend to be out of the box. [laughs]

KAO: Okay!

PERISSONOTTO: I like to think about the things that aren't traditional. No, I would also say it's because I'm a geriatrician and palliative medicine physician. And as a geriatrician, one of the core principles of what we do--which is really what all of medicine should do or has always tried to do--is think about the person in the context of their overall life and what is in their family circle, their social circle, their societal circle. And in my own treating of patients, I was noticing differences in terms of some of my patients who did very well and stayed independent and others who didn't. And I was very curious about other factors that may be impacting them. And there were things that I was identifying that weren't depression and they weren't anxiety and they weren't this and they weren't that. And I started just randomly reading about loneliness, I don't remember how exactly. And I thought, you know, I think this is something we need to learn a little bit more about. And I started delving more into this. And lo and behold, I then started doing this research and realized wow, it actually does have a bigger impact, and in my research, demonstrated increased risk of mortality and loss of independence.

KAO: Yeah. Well, I appreciate you sharing that. In follow up on what you just said a moment ago, I think one of the reasons why some physicians or many physicians may not ask patients about their feelings of loneliness is that loneliness can be uncomfortable for patients to talk about because it can feel like a personal failing to admit that you don't have the social network you want.

PERISSONOTTO: Yeah.

KAO: In fact, one study found, for example, that participants rated a fictional lonely person as being less likable, less competent, and less attractive than a non-lonely person. So, what do you think health professionals should do to reduce the perceived stigma around isolation and loneliness? And what can be done to better screen for loneliness and isolation?

KAO: Yeah. So, again, really excellent reflection on how this affects people. And I would compare this somewhat similarly to what we saw decades ago when we first started asking about depression. And though there's still some stigma around mental health, depression being part of mental health, there's improvement because there's been a more open dialogue around this is a significant thing that affects us and affects our health. And so, the more that we can open the dialogue and say, "This is important to me as your clinician. I know that these affect your health. And there are many people who experience this, so you don't feel like you're the only one," that opens up the dialogue and for people to feel safe to talk about it. So, that is part at the clinician level.

I will also say that in the greater public health view, it's really a national dialogue that's important. If we learn from our colleagues around the world, we see great work going on in Australia with the Coalition to End Loneliness. We see great work in the United Kingdom for the Campaign to End Loneliness and Isolation and their appointing of a Minister of Loneliness. This national dialogue says, "This is important. It is not something to be embarrassed about. And as your health care provider, as your health care team, as your community, we need to be open about this."

KAO: Yeah, I think you're--

PERISSONOTTO: Sorry. Go ahead.

KAO: No, I think your last points are well made because there may be some who view this as a quote-unquote "soft and fuzzy" issue.

PERISSONOTTO: Yes.

KAO: It's not diabetes. It's not hypertension.

PERISSONOTTO: Right.

KAO: So, why are we looking at this or focusing light on it? But in fact, it has as much, if not more, health consequences than some of the quote-unquote "chronic conditions" that we continue to flesh out.

PERISSONOTTO: You're absolutely right. You're absolutely right. My colleague, Julianne Holt-Lundstad, who's credited with looking at the meta-analysis that attributed the risk of isolation being comparable to smoking, also looked at things such as obesity, air pollution, and exercise, and again, saw that the effects of isolation, or in the opposite direction, if you are socially connected, it's very protective to your health. So, it's important to think about that. But I think with this idea that it's a fuzzy thing and not measurable and quantifiable has been one of the things in why it's hard to integrate some of these things into our medical practice.

KAO: Yeah.

PERISSONOTTO: And whether we like it or not, when we have universal and standardized screening tools or identification tools, that also normalizes the process and gives it something that, as clinicians, we can kind of measure a little bit better.

KAO: Yeah.

PERISSONOTTO: And so, one of the steps to be able to get past the stigma and integrate it into care is, again, talking about it, and two, using validated instruments that we know can work to measure. So, in the report, we mentioned several different types of measurement tools. I will highlight a few. So, one of the most common ones used here in the United States, because there's some variability internationally, there's one called the Three-Item Loneliness Questionnaire.

KAO: Mmhmm.

PERISSONOTTO: What's nice about it is that it is quick. It is three questions. It's validated. It's been used in different languages. And it's pretty reasonable to be able to implement that into routine care.

KAO: Yeah.

PERISSONOTTO: For social isolation, there's a little bit more variety. And there's a little bit less consensus on the right tool. Interestingly, a prior report suggested that something called the Birkman sign would be a reasonable tool.

KAO: Yeah, I appreciate you identifying some specific examples, and we'll try to share some of those resources as part of this videocast.

I like to switch gears now from identifying and focusing on this as a problem, but how we can deal with it once we screen for it and so on, so forth. So, as you know, to protect the elderly and chronically ill from COVID-19, we've asked this population to isolate at home. While social distancing has been the response to the novel coronavirus pandemic, we probably need the exact opposite in response to the loneliness epidemic.

PERISSONOTTO: Mmhmm.

KAO: So, how can we protect this population already at high risk for loneliness from the health risks and consequences that come with it?

PERISSONOTTO: Yeah. So, it always feels terrible to say this, but I'm going to say it anyway. We need more research as usual. And what I mean by that is that we are protecting people in the short-term by isolating, by physically distancing, but we have no idea how long it takes to actually have poor health effects. So, one of the things that's needed is actually understanding how long do you have to be lonely or isolated, or at what degree to have you have that negatively impact you? So, that's a call-out to our policymakers, our funders to really think critically about this and the research around this area.

The second thing I would say, which is a little bit more practical, is we have gone from this absolute level of panic and pandemic and crisis to now, how do we recover and redefine what social connections mean, and what type of physical distancing is appropriate? And what that means is how have we gone from this situation to zero contact, and is there a middle ground? So, for example, we have said you have to be distanced at six feet. It turns out, with some of the new information from the World Health Organization, that three feet also provides some reasonable protection. But there's also this thing, I can't touch you when really, if you look at the data, it's prolonged contact that gives you a risk. So, is it really, as I think about, I'm about to have a baby in a month. Can I hug my mother? Yeah, probably I can, as long as I've been safe and we do other things. But that's not a prolonged contact if I'm really giving her a quick hug. So, how do we redefine this and reestablish normal and be cautious but remember the importance in our overall health and picture that social connections are still very important and integral to our health?

KAO: Yeah. Well, I appreciate your points there. And congratulations on your coming critical, important happy life event!

PERISSONOTTO: Thank you. [laughs] Yes, hopefully happy.

KAO: So, I think you may want to be at some moments by yourself.

PERISSONOTTO: [laughing] Yes!

KAO: You may want to cherish these moments now, because. [laughs]

PERISSONOTTO: I know. I have a good excuse right now. Yeah.

KAO: Right, right, right.

Obviously, we're also very interested as an ethics journal on vulnerable population.

PERISSONOTTO: Yeah.

KAO: And so, people living in institutional settings, such as nursing homes, which have seen some of the highest COVID-19 mortality rates. Assisted living facilities, and prisons are quite literally isolated from many parts of society. So, individuals living in rural areas are also particularly vulnerable as well.

PERISSONOTTO: Mmhmm.

KAO: What should and can be done to help these vulnerable communities avoid some of the long-term consequences of loneliness and isolation?

PERISSONOTTO: Yeah. So, I think there's a few things. And I think the focus on vulnerable populations, both in institutionalized settings and even thinking about other vulnerable populations, which is critically important right now given our nation's events, to think about minority populations, populations that are being targeted as being different and how they may already be experiencing a baseline level of isolation and disconnectedness from the rest of society. So, really important topic. And certainly, we need to understand more specifically about these vulnerable populations. And that's one of the things that we highlighted in the National Academy of Sciences report, that this is a gap in the literature. But we also know that certain groups and certain ethnic groups are at higher risk of loneliness and isolation.

With regard to institutionalized living or congregate living situations, there's a couple things to think about this. Unfortunately, the national dialogue has really grouped all of long-term care and all of congregate living in one place as one risk level. But a population in a nursing home is potentially very different than a population in assisted living versus a population that may be in memory care. So, it's teasing that out a little bit more in terms of what are the unique risks of all of those groups? And then again, it's thinking about, in the short-term, we have to protect the public good and safety, but where are the individual rights?

And from an ethics perspective, what's been pretty distressing to many of us as geriatricians are that regulations and rules and recommendations are being placed on older adults and vulnerable people without asking what they want. So, it may be, and that's an institutional settings, but it may even be family members deciding for their parents, we're not going to see you because we don't want you to get sick. Rather than saying, "Hey, can we have a discussion about how are you seeing your risk? Can we still see you and minimize that risk? Or are you OK with this? Or what is your preference?" Because some older adults may actually say, "You know what? I would prefer to see you for a small amount of time because of my quality of life rather than not see you for months. And how can we do that safely?"

KAO: Yeah. I think that's a good, nuanced point that I think if we could turn the clock back on this pandemic, hindsight is always 20/20. And I think that many things that we rushed to do probably was seeing everything as a nail, so you use a hammer.

PERISSONOTTO: Mmhmm. Yeah.

KAO: So, I really appreciate your last point. So, so far, we've primarily focused on older adults, but younger Americans are also at risk for loneliness and isolation, especially given how many people are working from home these days, including the both of us at this point,

right now at least. A recent study found that nearly three quarters of millennials reported feeling lonely.

PERISSONOTTO: Yeah.

KAO: And while studies have found that tools like video chats may help elderly adults feel less lonely, some research has shown that loneliness may actually subside when younger adults reduce their kind of onscreen or social media usage.

PERISSONOTTO: Yeah.

KAO: So, what do you think health professionals can do to help this younger population during and after this pandemic?

PERISSONOTTO: Yeah. So, you're right. In many ways, there's almost a bimodal curve, and there's some parts of aging that put you at greater risk of loneliness and isolation because of changes in relationships, functional impairments, sensory impairments. But there's another part that may be protective as we get older because we have differences and changes in life satisfaction. But the younger populations are actually, I think you're right, there's actually emerging literature that we may actually need to be even more concerned about the younger generations. And the way to frame it, I think, and to help think about our younger populations is, how are we using technology, and how are we conceptualizing relationships?

So, some of this literature goes back quite a bit, quite a long time in terms of how our societies have changed, in terms of even nuclear families and even how we have general social contact. And if you are relying on technology as your only social interaction, there's concerns about the quality of those relationships, the satisfaction, and the depth of those relationships. So, it's forcing us to really think about what we value, how we interact with others, and to rethink what is meaningful to us. So, I don't know that we know enough yet about how to help our younger generations. But it is, I think this is a time for us to pause and really rethink of how we're engaging with others.

KAO: Yeah. No, I think it's forcing a lot of reflection at the individual and collective level, this pandemic.

PERISSONOTTO: Mmhmm.

KAO: There's no doubt about that.

PERISSONOTTO: And because for some people, I think when you're using technology or Zoom, you know, I use so much during the week that I'm Zoomed out at the end of the week, you know.

KAO: [chuckles] Yeah.

PERISSONOTTO: I just, I can't do another one. I want that in-person.

KAO: Yeah.

PERISSONOTTO: And for other people, it's a reminder of what they don't have. And yet for others, if it is the only contact, it is absolutely phenomenal and incredible. So, it's just, is it replacing something, or is it an augmentation? And how often are you using it?

KAO: Right, yeah. Good point.

So, as we near the end of our conversation, I know that some have pointed, and I think we've alluded to this already, that this pandemic's silver lining, if you can call it, because it has given many of us an experiential appreciation of the consequences of social isolation and loneliness.

PERISSONOTTO: Mmhmm, mmhmm.

KAO: So, what do you think we can do to help avoid the curse of short memories from a patient care and public health perspective?

PERISSONOTTO: I think it's this has allowed us to put ourselves in the place of other people where this is the norm. You know, in my own practice, I take care of a homebound population who are already isolated. For some of those people, this is no different than usual because at baseline, they're not going out of their house. It's actually the people where this is a change where it's been the most distressing. So, I'm hoping that it allows us to have a moment of empathy and of reflection and saying, "I am lucky that I have my liberty and I have my ability to walk and talk or whatever it is to go out. But let me be reflective of the people that this is not the norm." And let us not forget that we are all aging, and we are all at risk. And this isn't going away. And so, stopping and just to see the world right now slow down. I mean, there's other ways my life is faster right now because I've been so busy. But there's other ways that it's actually made us slow down and really think about others. And I'm hoping that we will have a better positive view on the importance of relationships and on aging. And unfortunately, we have a pandemic of ageism in this country and in the world where we don't value people who are marginalized.

KAO: Yeah, no. I certainly appreciate your last points about empathy. We certainly need to have more of that in this world. Empathy for others like us, and probably more important, empathy for people who we think are not like us.

PERISSONOTTO: Absolutely.

KAO: So, I want to thank Dr Carla PERISSONOTTO for sharing her expertise and insights with our audience today. Carla, thank you for being a guest on *Ethics Talk*.

PERISSONOTTO: It's wonderful to be here. Thanks for inviting me.

KAO: For more COVID ethics resources, please visit the *AMA Journal of Ethics* at JournalofEthics.org. And to our viewing audience out there, be well and be connected. We'll see you next time on *Ethics Talk*. [bright theme music plays]