Social Isolation/Emotional Loneliness in Older Adults with Congestive Heart Failure

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Abstract

Social isolation is a component of loneliness and occurs due to a discrepancy between an individual's perceived or desired versus actual relationships. The word isolation is commonly defined as separate from others, but this can be misleading. An individual may be married, employed or have many social connections yet still feel apart from others due to self doubt or internal conflict. It is important to make the distinction between maladaptive isolation and time alone. Adjustment periods to different environments, roles or phases in life very often require concentrated thinking and less social contact. Distancing oneself from an emotionally painful or negative situation can also be considered restorative. Extended periods of maladaptive social isolation results in loneliness, as well as persistent alterations in immune system function and stress response. Studies from the epidemiological, psychological and cardiac literature all show a definitive link between persistent social isolation/emotional loneliness, disease progression and increased morbidity. This is particularly the case in the older adult population diagnosed with heart failure.
Keywords: perceived social isolation, loneliness, older adults, disease progression

Introduction

The percentage of older adults within the population is rapidly increasing. Although many are active and maintain a good quality of life (QOL), others are diagnosed with one or more chronic diseases (Heart Failure, COPD, Diabetes etc.). These can affect both physical health status and psychological well-being. Congestive Heart Failure (CHF), a common diagnosis in the elderly, is associated with cardiac and neuro-immune system dysfunction. Psychological distress caused by social isolation can either worsen perception of or cause symptoms such as: depression, fatigue and increased dyspnea/shortness of breath.

Why are social relationships important

According to Hawkley and Cacioppo (2002) :
- **Balance emotional and behavioral adjustment**
- **Prevent depression**
- **Enhance self esteem**
- **Reduce negative events associated with stress**
- **Promote healthier lifestyles**

Background

Social isolation is described conceptually in two ways

1. <u>Epidemiological Point of View</u>

Focuses on demographic and personal data such as marital status, formal employment, age and membership in organized religion.

2. <u>Psychological Point of View</u>

Focuses to a much greater extent on Maslow's and Erickson's constructs and the human need to feel connected. The impact of social relationships, not mere number(s) is important.

Peplau (1981) identified the following antecedents of emotional loneliness:
- **Termination (end of a close relationship)**
- **Separation (apart from loved ones)**

Background

- **Status change (role different from former peers)**
- **Developmental (quality of social relationships)**
- **Demographics (work, home environment)**
- **Personality (low self esteem, poor social skill)**

<u>Key Points</u>
- ❑**Social isolation is often referred to as *emotional loneliness***
- ❑**Imbalance or discrepancy between an individual's perceived versus actual relationships**
- ❑**Planned time alone does not mean isolation.**
- ❑**Distancing oneself from a painful situation can be restorative.**
- ❑**Studies indicate a link between *persistent* social isolation and increased morbidity /mortality**
  (cardiac, epidemiological and psychological literature)

CHF

➢**is characterized by impaired myocardial contractility**

➢**affects primarily older adults ***

➢**associated with increased morbidity and mortality especially if not well managed**

Most frequent cause of readmission

Risk Factors

Previous myocardial infarction	**Smoking**
Hypertension	**DEPRESSION/APATHY**
Non-adherence to treatment protocol	**Vascular disease**

Overview of Literature

Detrimental Effects of Social isolation/Emotional Loneliness

<u>Physiological-</u>
- ❑ **a. sudden surge or blood pressure instability (systolic hypertension)**
- ❑ **b. immune system dysregulation and vulnerability to infection**
- ❑ **c. increase in measured blood cortisol (stress) hormone levels.**
- ❑ **d. sleep disorders which increase risk factors associated with cardiovascular disease**

<u>Coping strategies-</u>

can be ineffective without positive contact/support and affect decision making

Social Isolation and Disease Progression

A) Murberg & Bru (2001) conducted a study to examine how social isolation might influence disease progression and morbidity among CHF patients (final n=119). Two constructs were chosen to represent the social relations domain: perceived social support and social isolation (patient feeling unable due to CHF to maintain social contacts). Social networks were divided into (3) primary areas:

Intimate (spouse or partner)
primary (close family or long term friends) and
secondary (family, friend or neighbor)

B) Depression severity (Zung rating scale used), ventricular distensability (measured by Brain Natrieutic Peptide – BNP blood level) and New York Heart Association – NYHA activities of daily living Classification I - IV were included in the study.

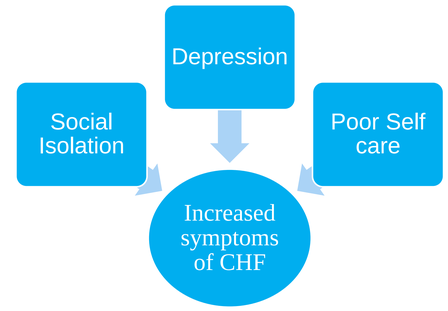
Class I no limitations
Class II minimal limitations with increased activity
Class III limitations with any activity
Class IV severe limitation in activity even at rest

Results

A Cox Proportional Hazard model was estimated with social isolation as a predictor variable with the Zung score, pro ANP value, NYHA class and age as additional covariates.

Social Isolation was a *significant predictor* of mortality among patients with CHF (p=.038)

Predictor of Negative Outcomes



Discussion

Social Isolation and Chronic Disease in the Elderly
(note commonalities in red)

CHF SYMPTOMS	DEPRESSION SYMPTOMS
Fatigue	Sad affect
Low energy levels	Loss of interest
Appetite change	*Low energy*
Peripheral edema	*Fatigue*
Sleep disturbance	*Appetite change*
Cognitive impairment	Sleep disturbance
Decreased motivation	Cognitive impairment

As the preceding table indicates comorbidities often cause similar symptoms. The combination of CHF and Depression is particularly dangerous in the elderly since the resultant fatigue and lack of energy are severe. In a study by Aldred, Gott & Gairaballa (2003) older adults described the feelings associated with reduced social interaction and chronic disease: loss (roles, self concept, work) uneasy uncertainty, loneliness, anxiety related to symptoms. Management of CHF is complex and requires a team approach. Older adults have, in many cases diminishing social contacts, and in order to prevent reduced self care ability every opportunity to utilize community, professional and social resources should be made available

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