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THE EPIDEMIC OF LONELINESS

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THE EPIDEMIC OF LONELINESS

(8:00 a.m.)

MS. DRASSER: Good morning, everybody. It's 8:00 a.m. This is the final morning of Spotlight Health. I just want to thank you all for being here. We are so not lonely in this room.

My name is Katie Drasser. I'm the managing director of Aspen Global Innovators Group. In fact so not lonely that we can't pipe down a little over there my people. Anyway, welcome. I am -- this -- I am not supposed to say this, but this was one of my most favorite sessions to plan for this year in part because of Katie Hafner, who is leading this discussion. She wrote an article last September on the epidemic of loneliness mostly in this country, but there are trends around the world. And it plays into how we relate to each other, it plays into our own health and well being, it plays into how we vote, just sort of all kinds of things that's related to this trend of loneliness.

But Katie is a -- also a Katie -- bona fide journalist. She started her career in journalism focusing on technology and has really moved into this space of wellness and right now really digging into some pretty interesting questions around aging specifically. But her article changed our editorial teams' mind. And on a side note, she has also been so much fun to plan with and work with and sort of like learn from. And I'm very grateful to you. So, enjoy.

MS. HAFNER: Katie, thank you, thank you so much.

(Applause)

MS. HAFNER: Thanks, Katie. Can everyone hear me? Is that good? Okay, great. So this is -- there -- this is not going to be a happy uplifting session. There is no joy in Mudville this morning.

(Laughter)

MS. HAFNER: If you're looking for yucks, this is not the place. It's a very profound and I have to say it's a surprising topic -- it was to me. I'll tell you a little bit about how I started on the story. I decided to write the story. I pitched it to my editors at *The Times*. They loved the idea. And it turns out that the U.K. is far ahead of the U.S. in dealing with this problem of loneliness among the ageing. I mean, loneliness is a problem that cuts across generations of course, but I really focused on the elderly population because it is such a quiet devastation. Loneliness is something that Emily Dickinson called "the horror not to be surveyed," and if anyone should know about that it would be Emily Dickinson.

So one of the things I found: the U.K. has many, many programs in place. And before I introduce our panelists, I thought I would just read the lead of the story that I wrote. I went to the U.K., did a lot of reporting there on the ground and one of the things I did was go up to Blackpool, England, which is north of Liverpool. It's one of these sort of seaside resorts gone to seed really and they had this -- that they have this call in center. It's a 24/7 call in center called the Silver Line. And I listened in. They let me listen into these calls coming in from very elderly people. And I -- it was amazing: these really patient people taking the calls just would stay on for as long as these people wanted to stay on.

So here's how the story started: "The woman on the other end of the phone spoke lightheartedly of spring and of her 81st birthday the previous week. "Who did you celebrate with, Beryl (phonetic)?" asked Allison, whose job was to offer a kind ear. "No one, I" -- and with that, Beryl's cheer turned to despair. Her voice began to quaver as she acknowledged that she had been alone at home not just on her birthday, but for days and days. The telephone conversation was the first time she had spoken in more than a week."

So I'm going to introduce our panelists. Everyone I talked to -- by the way, when I started the

story -- there are very few researchers in the world who do true deep dives into this. And Julianne Holt-Lunstad -- everybody I -- who's all the way on the far end there, everyone said you have to talk to her, everyone said. So all roads lead to Julianne.

(Laughter)

MS. HAFNER: She is a professor of psychology and neuroscience at Brigham Young University, where she's also director of the Social Neuroscience Lab. Her research takes an interdisciplinary and multilevel approach to understanding the associations between social relationships and long term health outcomes. She has received the citation award for excellence in research by the Society of Behavioral Medicine and many more that you can read about in the Festival book.

Next is Dixon Chibanda, a psychiatrist and a Wellcome Trust researcher at the University of Zimbabwe. His interests include community mental health with a focus on integrating mental health strategies into existing public health programs. He is also developing testing and validating alternative interventions to address mental, neurological and substance abuse disorders. He developed -- and this is the most relevant thing for our panel -- the friendship bench program, a community-based mental health intervention that has been scaled up to more than 70 primary care clinics just in Zimbabwe.

Next is Carla Perissinotto. Did I say that right?

MS. PERISSINOTTO: You did. Fantastic.

MS. HAFNER: And again, all roads also lead to Carla for this story -- is an associate professor in the Geriatrics Division -- and geriatrics -- geriatricians, there's a special place reserved in heaven for geriatricians --

(Laughter)

MS. HAFNER: -- of the Department of Medicine at

the University of California, San Francisco. She is certified in internal medicine, geriatrics and palliative care -- another halo specialty. Since joining the UCSF faculty in 2010 as a clinician educator, she has received multiple honors for teaching excellence and has developed curricula on elderly patient care. She has a special interest in teaching primary care doctors how to more effectively recognize cognitive impairment.

So starting with that -- Carla, I hope I don't embarrass you with this -- but there was a part of the story that got cut and it had to do with Carla and it was the -- it helped end the story. And so I thought I would just read that to you so you get a sense of what Carla's work is like.

Dr Perissinotto, who often makes house calls said she recently offered a patient UCSF's tele-health service, a virtual house call with a physician via video. The patient turned it down saying the physician's visit was the only social contact he was likely to have all month. Dr. Perissinotto said there are days when the loneliness her patients feel brings her to tears.

"When my husband got home, he found me crying," she wrote in a recent e-mail after making a home visit to a 98-year-old patient whose husband died six years ago. Her life has been reduced to wheeling herself from her bed to the commode to the dining room table. She doesn't want to go out and she doesn't want me to come up with ideas to make her feel better. She just wants to die.

So let's dive right in. And I really have always been curious, and I think when I was reporting the story, I did not ask you two, Julianne and Carla, what on earth possessed you to -- you, Julianne, especially -- to start researching this topic?

MS. HOLT-LUNSTAD: Well, I can tell you how it evolved. I originally -- my training is in health psychology and my original work was on stress and health. And I did a lot of research in a experimental lab, a psychophysiology lab, where we would bring people into a lab and stress them out --

(Laughter)

MS. HOLT-LUNSTAD: -- and do very creative things to create stress in a lab and then we would measure their physiological responses. And, you know, the idea was to get an indication of how this is affecting their health relevant indicators.

And what we found was that social support and relationships had a profound impact on this. And so it kind of went from stress to social support and how relationships can either help us cope with stress or can actually be sources of stress. And then this evolved into really looking and really being primarily interested in the overall effects of social relationships, because they do have a profound effect on health, wellbeing and even longevity irrespective of stress. So that's just part of it. But relationships and health, that's kind of the journey it took.

MS. HAFNER: And, Carla, you have published one of the few, if not the only, truly medical. Tell us about that paper?

MS. PERISSINOTTO: Yeah. So what was interesting -- and I've said this a lot recently -- is that there's actually a decent amount of work in this area in loneliness and it's becoming even more so I think as the demography is changing around the world clearly with all of us ageing as we speak. And there's a lot of work, but none of that was really in the medical literature. And so my research in 2012, which really followed 1,600 people out of a national study called the Health and Retirement Study and we followed them over six years to really see whether loneliness posed a risk to death and loss of independence.

As a geriatrician, my main focus is really what keeps people independent and what keeps people at home, if that's their goal. And so my study really looked at those risk factors. And it was in the Medical Journal, which was the first time -- really is telling physicians and other healthcare providers: "This isn't something just

relegated to the social sciences fields. We actually have to pay attention to this in terms of a real public health threat."

MS. HAFNER: And your findings were?

MS. PERISSINOTTO: And my findings were that loneliness is an independent predictor of functional decline -- so by close to 60 percent increased risk of functional decline and a 45 percent increased risk of death just solely by being alone -- sorry, by feeling lonely. And that means -- when we mean independent, it means that we are not -- we are ignoring or that it excludes depression and it excludes the typical risk factors.

MS. HAFNER: And let's do some definition clarity here. We have loneliness and then there's social isolation. Who wants to take on that?

MS. HOLT-LUNSTAD: Why don't you start with that?

MS. PERISSINOTTO: Yeah. So I would say that this is a really important thing. What you'll notice in the literature whether it's in the public media or in papers, the terms are often used interchangeably. But I think this correlates a lot with what both of my colleagues works are doing, is that loneliness is really the subjective feeling of being alone. So it's really what I experience. You cannot tell me if I feel lonely. I may look lonely. But it really depends on what's going on inside of me. And that's in contrast to social isolation, which is something that's quantifiable, so the number of relationships and contacts that someone has.

And the reason that's important again is how we target interventions and how we might want to help people. So it may be that I'm surrounded by people in this room and still have a sense of loneliness. So putting me in a room is not necessarily going to help.

MS. HAFNER: Is there anything you'd like to add to that?

MS. HOLT-LUNSTAD: Well -- so as far as understanding the potential impact, so as Carla was mentioning, there's the distinction between loneliness and social isolation. And so I did a meta analysis, looking at the effects of these. And we also -- and just to clarify, a meta analysis is in essence gathering and synthesizing all of the published literature on this. So you're combining the data from multiple studies. So we combined the data from 70 separate studies. So it included over 3.4 million participants, and this included social isolation, loneliness and living alone. And all of them significantly predicted mortality.

And so it's important to recognize that it's not a one or the other, and if you're only looking at one, you're potentially missing risk from the other. The other thing I could add is that on the flipside that there is protection associated with being socially connected. And so --

MS. HAFNER: What does protection mean?

MS. HOLT-LUNSTAD: Protection, lower risk, so people live longer and have healthier trajectories. And so this can include things like the size of one's social network, the extent to which they are involved and participate in a social network, the extent to which they perceive social support. So whether it's actually support they receive or the perception that it's available if needed -- and then also the quality of these relationships. And in another meta analysis, we found that all of these are associated with longevity. And so it is important to consider all of these indicators of social connection or on the flipside lack of social connection.

MS. HAFNER: Is this surprising to -- it was so surprising to me when I was doing this story. Is it surprising to everyone? Yeah. Tell me, there's a researcher at the University of Chicago who -- wait, what's so funny?

SPEAKER: It is a -- I believe we all know.

MS. HAFNER: Oh, people said no? You guys are not surprised by this?

SPEAKERS: No.

(Laughter)

MS. HAFNER: My goodness gracious! So are you all just complete pessimists and -- well, good. That's good to know that the tenor of the -- that where we're headed here. So tell me if this surprises you too? And so John Cacioppo at the University of Chicago, whom I'm sure you know, has done research that shows that loneliness is an aversive signal much like thirst, hunger or pain and that -- oh, everyone -- no one is surprised.

(Laughter)

MS. HAFNER: Well, I can't wait until we get on to the solutions section of the --

(Laughter)

MS. HAFNER: And another thing is that some -- that there has been some research -- some of the first research done at MIT by a young researcher named Kay Tye, who's wonderful, who found that mice -- that when mice were housed together, dopamine -- and whatever else they do when they are housed together --

(Laughter)

MS. HAFNER: -- that dopamine neurons were relatively inactive. But after the mice were isolated for a short period, the activity in those neurons surged when the mice were reunited with other mice, which I thought was actually great -- maybe not surprising, but very interesting.

(Laughter)

MS. HAFNER: And so now that we've sort of -- would you say we've laid the foundation of sort of the

danger of this problem? And I'd really like to get to, you know, what we've seen as some of the solutions that have started coming along. And as I have said, the U.S. is woefully behind in this and what I like to do in the next, you know, 30 minutes is solve it.

(Laughter)

MS. HAFNER: And in the U.S., I mean, really we've got to get our act together for how we deal with this problem. And so on that note, Dixon, tell us about the friendship benches?

MR. CHIBANDA: Sure. Before I talk about the friendship bench, maybe I should just give you my perspective. You know, often when you say hello to somebody, you don't expect them to say I'm lonely or I'm isolated. I think that's where the problem begins. We're not comfortable with statements that are emotionally loaded. And so the key problem is: How do you undo that? How do we all become comfortable with that which is uncomfortable? Because as human beings, naturally we want that which is comfortable. I mean, it's not rocket science. But as we interact on a daily basis, I think it's all about finding that equilibrium and that's essentially what our work on the friendship bench is all about. I mean, it's -- again, it's not rocket science. It's just a bench with a grandmother, you know. But I think --

MS. HAFNER: Grandmother -- tell us about the grandmother?

MR. CHIBANDA: Sure. So these grandmothers deliver -- essentially it's a CBT-based intervention, cognitive behavioral therapy. But over the years, we've obviously modified it, you know, to suit our cultural sort of context and we've identified more appropriate sort of local idioms of distress and we've come up with a mental health lexicon that we use in our own sort of setting, which really sort of connects with the people. Because a lot of the terms that we use, you know, in the biomedical or Western sort of field just don't gel with African folks. It just doesn't work to walk up to someone and say

you're depressed. They'll probably think you're nuts, although they have the symptoms of depression.

And so we've had to find words that are more appropriate. For instance, it's more appropriate in Africa for someone who is depressed to say they are thinking too much. In my country it will be a word called kufungisisa. So it's finding the words that people can identify with and then working around those words, and that's essentially what the friendship bench is about in a nutshell obviously. I can talk a lot more about that.

MS. HAFNER: Yeah.

MS. PERISSINOTTO: If I could add? I think you touched on some really important things and what I'll add is: not only is there a stigma around talking about loneliness, but the second thing that underlies a lot of this particularly in the United States is the large degree of ageism that we have. And so we want to ignore older people. I've been in hospitals where the older adults get sent to a different ward because they are not considered to be good teaching cases for students.

MS. HAFNER: Really?

MS. PERISSINOTTO: Yes. And so you have those sort of things. So not only are we not wanting to teach medical students and our future health care providers about older adults, but then we don't want to talk about what it looks like to not age successfully. We only want to hear about healthy ageing.

So now you have someone who is older and they are feeling lonely, why would they want to talk about that? And I think, as you said, some people do not identify with the word lonely. So I've had patients, who, if I ask them, they will say, "No, I don't feel lonely." But if I ask from what we -- what is often used, something called the three item loneliness questionnaire -- I ask someone, "Do you feel left out? Do you feel isolated and do you lack companionship? Suddenly the answers are yes when those are actually the signs of loneliness.

So how do we get around it, but then also how do we start becoming comfortable so that someone can come to their health care provider and say, "You know, Dr Perissinotto, I'm actually feeling incredibly lonely." And that should be a red flag for me. Like, forget their blood pressure and cholesterol, which is super boring --

(Laughter)

MS. PERISSINOTTO: -- and instead let's actually talk about what's actually really affecting everyday life.

MS. HOLT-LUNSTAD: Well -- and I guess I can add also is that while this is obviously an important issue among older adults, we need to acknowledge that it's not isolated to just older adults. And indeed our research shows that you see it across the age spectrum. In fact we find no effective age in one meta analysis and in the second one we actually find a stronger effect among those who are under 65 relative to those who are over 65. And so we can all benefit from this and I think we all to a certain extend have this stigma associated with that.

MR. CHIBANDA: Yeah.

MS. HOLT-LUNSTAD: And I think that's part of the reason why I also prefer to focus on the potential health benefits of being socially connected, because that's something that we can all aspire to rather than admitting that we have some kind of deficit, which can be stigmatizing. And so then that can have a broader impact on the population rather than focusing on, you know, an isolated end of the spectrum.

MS. HAFNER: Well, I'll ask the question that I'm sure will be asked by the audience, so I might as well just ask it. This whole question of social media and how we're more connected than ever, but more isolated than ever, do you subscribe to that? What are your thoughts on that? All three of you. I like to know.

MS. HOLT-LUNSTAD: You want to go first or --

MS. PERISSINOTTO: Go for it.

(Laughter)

MS. HOLT-LUNSTAD: Well, I can first tell you, as far as what the data says -- so as I mentioned, I did another meta analysis that had over -- well, it had 148 different studies. But these studies follow people. They look at whether they are lonely, isolated, you know, social network size, etc cetera, at one point in time and then follow them over years, often decades.

Most of these studies were done or started prior to the time when social media was widely used. So as far as the broader scope of the literature, I think that question is still open in terms of where the data stands.

However, we do see some indicators that we're becoming more isolated as a population. So in the U.S. there has been a significant increase in the number of people who are reporting significant loneliness, as Carla's work has shown. But since 1985, there has been a one-third reduction in the size of people's social networks. We now have the lowest rate of married adults in the U.S. in recorded history. Household size has decreased. There's an increasing rate of childlessness. When you take that and put that together with an increasing ageing population, that would indicate that there are going to be less familial resources to draw upon in older age.

So we see these trends of people becoming more socially isolated over the last few decades and we also see that people are -- that technology is now the primary means of communicating socially.

Now, what we don't know is the direction of that effect. Is it that because we're becoming more isolated that people are turning to technology because they are craving that connection, as John Cacioppo talks about, that need to connect? Or is it that because we are seeing what others are doing online, we feel like, "Okay, I'm covered, and don't actually -- you know, interacting that becomes a replacement and so it's leading to greater isolation?

MS. HAFNER: Dixon?

MR. CHIBANDA: Yeah. So I think what we found in our work is that people are less likely to use -- when people are lonely, they are less likely to use technology to address that loneliness. Because, you know, if you think about it, the resources are out there if you're lonely, isn't it? You can get onto your mobile phone. You can find solutions. But people who are lonely inherently have other mental health issues. You know, they may lack motivation, you know, that drive. And I think there are some studies that actually show that technology itself does not guarantee that it will enable you to achieve the outcome you're looking at in terms of making you happy.

So it's more about that motivation, is it really there that motivation to use technology to make you happy? And what we found on our work on the friendship bench is that initial first session with the grandmother, that contact with a human being is critical, because that then sets, you know, the sort of the platform for that person to then go out there and use that technology to actually make them happy.

So our clinical trial, which is published in JAMA shows that the first session with a grandmother improves a person's ability to use technology to make them happy as opposed to just giving people technology. So I think what our study shows is that human contact is key, you know. Yes, we can leverage technology, but to some extent that -- the power of human contact cannot be underestimated, no matter how technologically advanced we become.

MS. HAFNER: Carla?

MS. PERISSINOTTO: I was just going to add: so as Katie mentioned at the beginning -- so part of my work as a geriatrician is that I make house calls to homebound adults. I live in San Francisco. San Francisco is a city of hills and stairs and so many of my older adults are homebound literally because of the stairs in the home.

They can get around inside the apartment, but beyond that they can't. And though we have a lot of new technology and resources for people, there is that craving of connection. So we're struggling as a team as we're trying to grow our program because there are certainly much more need in terms of people needing physician home visits than what we can supply. And we are experimenting with the use of technology in tele-health.

But as you said, I've offered this service and it's like, "Wait a second. This is instead of you coming to see me. Why would I do that? And so that's the struggle that we're seeing. And I know -- don't tell Medicare now --

(Laughter)

MS. PERISSINOTTO: -- but I know that when I go see patients, it is often my visit, not my checking the blood pressure and these things that's actually having an effect -- and maybe both of those things. And I think that's where we are with the research and where do we move things forward.

And I'll say that just on a personal note: it's very interesting that I'm not on Facebook. I haven't been. I'm like the last person holding out I think in the world.

SPEAKER: And me, and me.

MS. PERISSINOTTO: All right, all right. I like that. So --

(Laughter)

MS. PERISSINOTTO: But what I'll say about that is that it's just not a one size fits all when we start talking about intervention, so it doesn't work for me. It works great for my sister. She doesn't like that she has to call me to tell me what's going on in her life. She wants me to look online.

(Laughter)

MS. PERISSINOTTO: But it's just -- that's just the way how we try to figure out how to connect with each other. So it's thinking there are absolutely ways to leverage technology and it's going to work for some people, but not for everyone -- so how do we work with them?

MS. HAFNER: Okay. I'm going to open it to questions. We only have 20 minutes to solve this problem and the pressure -- yes, right here. And there's a microphone coming your way.

MR. COCHRAN: Hi. Thanks so much. This is a fantastic panel. I'm Seth Cochran and I've just founded a charity focused on elder abuse, elderabuse.org. And what we're trying to do is -- it's the first charity sort of advocating to the public and loneliness and isolation is a major --

MS. PERISSINOTTO: Risk factor.

MR. COCHRAN: -- risk factor. I just wondered if you could talk about the research or any sort of, you know, academic studies that link this -- you know, these -- loneliness and isolation specifically to financial exploitation or elder abuse?

MS. PERISSINOTTO: So I'll say that I don't know the specific research. I know that -- I was just speaking at another conference where this came up quite a bit. We know that -- I think there's a couple of things to think -- ways to think about loneliness and why it places us at risk. So the financial exploitation piece I think we can think about it theoretically in that we all know that advance care planning or having a power of attorney is incredibly important, yet the majority of adults don't have this. And so you have someone who may be lonely and isolated, but they don't have those documents to protect themselves, then they're at greater risk for exploitation.

I've seen that time and time again in my practice: the elder abuse that is either because they don't have those paperwork set up and so they're are at

risk and -- or it's the phone scams because some is alone and just wants the phone call.

MS. HAFNER: Phone scams.

MS. PERISSINOTTO: I put my patients on do not call list and even still it's a problem. So I don't know the direct research, but we're heading there because we know it's a huge risk. So thank you for your work.

MS. HAFNER: There is a hand waving so aggressively.

MS. PERISSINOTTO: Yeah.

(Laughter)

SPEAKER: My partner here and I are world's experts on CD and the person I mentored with was a man by the name of William Whyte, who wrote a book called *The Social Life of Small Urban Spaces*. We worked in 3,000 communities about how you create a sense of place where people can come together to actually interact with other people. But putting a benching out is a radical idea.

MS. PERISSINOTTO: Yeah.

SPEAKER: -- because of who might sit on it.

MS. PERISSINOTTO: Right.

SPEAKER: And then when you actually do a bench that's actually comfortable, that's even more difficult because people are afraid that people might spend too much time in that bench.

MS. PERISSINOTTO: That's true.

SPEAKER: So there's a whole psychology going against you to do it, to be even connected. It's phenomenal.

MS. PERISSINOTTO: Right.

SPEAKER: And architects and landscape architects create objects to look at, but not to be used. So this is a very deep distressing problem. And it's -- we have a network around place making and we have people who are place making leaders around the world who are countering that on many levels. I mean, there is so much more to this about streets and how you can't walk on streets and be part of streets. I mean, I could go on for a while, but that's --

(Laughter)

SPEAKER: Let me just add that one little thing, is what we're finding is people don't have places to go --

MS. PERISSINOTTO: Yeah.

SPEAKER: -- in their communities.

SPEAKER: Yeah.

SPEAKER: And think about Aspen, I mean -- because in Aspen where do you go, public space? And that's the part -- you can't say anything more. And somebody else.

(Laughter)

SPEAKER: Can I say something.

SPEAKER: Great team.

MS. PERISSINOTTO: So I'm just going to add to that there's some -- I think getting back to this idea of ageism: so it's not just the public spaces and benches, but there's an idea of how do we move to intergenerational, you know, living arrangements or social arrangements. And I'll put a plug that my husband and I live in theoretically one of the worst neighborhoods in San Francisco, which we left. But he's planning on opening a restaurant and in my public health world I already have plans for how it's going to be a place and it's dementia friendly. And so we're working on it.

MS. HAFNER: Really? Okay. Oh goodness! David, yes.

SPEAKER: Thank you. This is a wonderful panel. My name is David. I'm a primary care physician. I'm also a dad who has two little kids and I occasionally get lonely even though I'm very socially connected, right -- I think I am. And my question is about gender. And I know there was a *Boston Globe* article that came out recently sort of highlighting about men in particular in middle age and how men relate to each other differently from growing up and teams and sports. And I'm curious if your research or any of the things you found have found differences between men and women.

MS. HOLT-LUNSTAD: So I can just start by saying, first of all, when we look across all of the data, it affects men and women equally -- so as far as the effect of it, right? And that makes sense that if we are -- if this is, you know, adaptive. And so, as John Cacioppo has argued, that to connect to others is a biological need and it ties back to the idea of being part of a group is adaptive to survival whether it be resources, protection from predators, all these kinds of things. It's very adaptive to be around others. And so we don't find any difference between that.

However, when it comes to the experience, that we do find some differences. So, for instance, in terms of the social support literature: women tend to prefer -- and this is on average of course, we're not talking about any one individual male or individual female -- but on average women tend to prefer emotional support, men tend to prefer and offer tangible support, meaning women like to get some sense of understanding about what problems they may be having, whereas men want to solve the problem.

(Laughter)

MS. HOLT-LUNSTAD: And again, this is on average. But that's just, you know, within the -- you know, kind of the social support literature. However, I think it was your work that you covered in the UK where they talked about how men prefer to be shoulder to

shoulder --

MS. HAFNER: Yeah, there's a --

SPEAKER: -- versus face to face.

MS. HAFNER: So just quickly one thing -- and you can read about it in the story -- there's this thing called Men's Sheds and it started in Australia. And the idea is that men don't talk face to face. They talk while they're doing something shoulder to shoulder. And so there has been this huge movement, which has not made it to the United States, of these Men's Sheds, where -- meaning that they go and they do woodworking together. And it's a powerful, powerful, profound part of the solution interestingly. In the white sweater, yes.

SPEAKER: So I'm curious if you can -- looking at these cuddle therapy and -- like there are cuddle parlors in (off mic) stressing the --

MS. PERISSINOTTO: Of course there would be San Francisco.

(Laughter)

MS. HAFNER: Of course in San -- I'm not surprised.

MS. PERISSINOTTO: Yeah.

(Laughter)

MS. HOLT-LUNSTAD: I could actually address that.

MS. PERISSINOTTO: Yeah, you go for it.

SPEAKER: Yeah, I'm curious what your reaction -- the reason this came to my attention is the NHS in the UK had identified loneliness and isolation as probably their biggest health problem that they had to provide coverage for as far as their expense. And so these cuddle lounges and -- yeah, it's a really interesting

relationship that they've identified.

MS. PERISSINOTTO: So I'm moving to the UK. No.

(Laughter)

MS. HOLT-LUNSTAD: So I guess I'll mention something about that. So I've done some studies looking at the neuropeptide oxytocin. And so for those of you who may be less familiar with it -- first of all, it's not oxycodone. It's oxytocin.

(Laughter)

MS. HOLT-LUNSTAD: And it's often been dubbed the cuddle hormone, the love hormone. But really it's a hormone that has been primarily identified with pregnancy and lactation. But it's been associated with social bonding, but also stress regulation. And what we find is with physical touch, hugging, holding hands, that there's a release in oxytocin. Oxytocin has also been linked to some health outcomes as well.

I did one intervention where we randomly assigned couples to do couples massages three times a week for a month and then controlled couples that just went about their everyday lives. And we found significant increases in the couples who were practicing this and in men decreases in blood pressure. However, there have been other studies where they use a massage therapist. And while they find short term changes like 15 minutes, it's not sustained -- whereas with an intimate partner those were sustained. So it suggests that there might be -- if it's done in a setting with strangers, whatever benefit there might be might be very short lived.

MS. HAFNER: On the end, yes.

SPEAKER: Good morning. Do you find loneliness more frequent in the United States versus other countries around the world?

MS. PERISSINOTTO: So I'll tell you that the biggest studies are in the United States and then in the

U.K. And so here our prevalence of loneliness in the research that I did was 43% in people over age 60, so pretty high. In the U.K., the studies that have been there it has been actually a little bit lower, so around 30%. But they also -- the way they did their prevalence study is also looking at severity. So overall loneliness being about 30% and severe loneliness in terms of all the time every day around 5%.

But the challenge in this area is that it's not studied in a lot of places. The other challenge and why we were talking a lot about definitions is how we're measuring it has been variable and it makes it a little bit hard to look across national comparisons.

MS. HAFNER: Yes.

MR. CHIBANDA: Yes. Maybe I could just add on to that as well about loneliness. What we find in our work is that it correlates a lot with depression and sometimes it's kind of difficult to tease out and differentiate between the two, you know. When we look at some of the screening tools that we use in our work, we find that most people who report feeling lonely or -- well, like subjective or objective, you know, also show a lot of symptoms suggestive of, you know, depression. And so often targeting the depression itself does -- can help, although you can get situations where loneliness presents, you know, in isolation as -- you know --

MS. PERISSINOTTO: And I'll add that in our study it was actually the majority of people were not depressed who were lonely. So probably some contextual differences --

MS. HOLT-LUNSTAD: Well -- and I'll just add to that: as far as the epidemiological literature that has established the health importance of this, because depression has such an important impact on health, it was important to distinguish between those two. And so the majority of epidemiological studies control for depression. So the effects that you hear about are over and above any health effects of depression.

MS. HAFNER: Alice.

SPEAKER: Hi. Alice from San Francisco. I just want to get back to the comment about the benches. So I'm a primary care doc for -- essentially for poor people in the safety net and so I can absolutely attest to this epidemic of loneliness and isolation.

SPEAKER: We can't hear.

SPEAKER: We can't hear.

SPEAKER: Oh! Can you hear me now? Oh goodness! I just want to go back to the comment about the bench. I was saying I'm a primary care doctor for the underserved and so I can absolutely attest to this epidemic of loneliness and social isolation. Often times my visit is the therapeutic touch.

MS. PERISSINOTTO: Yes.

SPEAKER: And at the same time I'm finding myself really resisting this need to medicalize it because it really is so rampant. And just wanted to ask you: What are the public health, community development, urban planning type measures that we can make that might have a bigger impact? What are the policies that we need to pursue to try to go a little bit upstream?

MS. PERISSINOTTO: So I would start by saying I think you're right, Alice, and we work in the same settings, so we probably encounter a lot of the same people. And there's a couple of things. One, I actually do think that identifying it and starting to talk about it is actually one of the first things, because if we don't know how big of a problem it is, it's hard to figure out what the policy is about it.

That the two other areas I would think about -- so if you think about how to address loneliness, it's trying to figure out: Is it someone intrinsically in terms of their stress response and how they're responding to their social environment? Is it not having access to social connections? Or is it a way to need to increase

social connections?

San Francisco has a particularly large housing problem. Some of the newer senior buildings -- and there's one in my neighborhood in the Bay View -- where a lot of the social planning is really around creating spaces within the buildings for socialization, so it's not just everyone goes into their room and that's it. So how do we create spaces? But then again looking at models in the United Kingdom or in your overall where you're having a mix in both older and younger adults.

The third thing I would say in terms of policy is let's think a little bit differently. Yes, we don't want to medicalize it completely. At the same time if it is having effects on our health, we need to think about what are the other ways to do.

So there's a project going on at Curry Senior Center, which is downtown San Francisco, looking at marginally housing homeless older adults and looking at pairing them with peers. And what we're finding preliminarily is that many of these folks have access and are getting public resources in terms of they have a case manager, they have meals on wheels, they have everything what that they need theoretically, but they're still feeling very disconnected. So is there a way to look at that?

I also think about in-home support services, and the way that we get these for low income seniors now is that they have to have a limitation with an activity of daily living to get services or a medical condition. But should we [be] thinking about expanding access to these programs for intervention such as loneliness?

MS. HOLT-LUNSTAD: Well -- and I'll just add: you know, you mentioned public health and acknowledgement, you talked about that. The last time I looked it was a few weeks ago, so things could have changed -- maybe a whole month, I don't know. But the last time I checked on the CDC website under social determinants of health, social relationships were not listed. And so that I see as a problem.

MR. CHIBANDA: Yeah, that is a problem.

MS. HOLT-LUNSTAD: And indeed there are other things that are kind of peripherally related, but the fact that it's not being acknowledged kind of an institutional level it is something we need to address.

Now, the former surgeon general, Vivek Murthy, who is here and spoke, certainly was interested in considering this as part of an emotional wellbeing initiative. But it's unclear at this point what that might take with all of the changes that are going on now.

MS. HAFNER: So unfortunately I think we only have time for maybe a couple more questions. Yes.

SPEAKER: I was feeling that millennials or even younger people are feeling more socially isolated because they don't believe in telephones, they don't want to call someone, they want to be texted -- and their life is so busy with work that they only have time to text and that is creating loneliness. Even finding someone -- they don't call or whatever. They have an app if they're at a place, and if they see someone's picture, they can just click on it. So how is this going to affect loneliness and isolation among younger people?

MS. HOLT-LUNSTAD: I'd say that is a huge question that we absolutely need to do systematic research on.

MS. PERISSINOTTO: Yeah, we don't know yet. I think it's a -- there's a lot of things I'm curious also as a geriatrician because I see a lot of cognitive impairment. I'm actually very interested in how all of our relationships and cognition are going to change because -- I mean, who remembers numbers or anything anymore. You look it up all on your phone. And so even our working memory and how we retain information is changing. So how our generation experiences dementia and cognitive impairment is probably going to change over the next several decades.

And you're right this idea of social connections and how people are relating, it's concerning, but it's not being looked at or at least not published yet. So we should all be worried.

(Laughter)

MS. PERISSINOTTO: I don't have kids yet. I'm wondering whether it's the right thing.

(Laughter)

SPEAKER: You know, it's nice to identify a problem. All you have to do is think about the war when they put Senator McCain in isolation, okay. We all know it's torture. The second thing is: What can we do with very little money and common sense? Number one, you go to a yoga retreat for $100 a night and they insist that when you see anybody walking by, you give them a heart to heart hug. Because when hearts connect --your actual heart -- and you hug a person, you bring up that oxytocin, whatever the --

(Laughter)

SPEAKER: Next, look at all the -- I total spend -- my name is Michele Rosenfeld (phonetic). I've had 10 careers. I wound up making money in the art world. But I studied at Columbia and I have like a degree in psychology, teaching, speech therapy, because my dad said, "You better have an insurance policy, don't get married for a meal ticket."

(Laughter)

SPEAKER: So I went into the art world because I sold all the art in the basement of Columbia University because I loved art. And when I got married, my husband paid the rent, I went into that business and I was very passionate about it, as I am about things that get to me.

Now, I don't know why in America we don't have kibbutzs in Harlem and also for older people. My parents lived nine years in a Jewish home in Miami Beach. They

couldn't have been happier. They could crotch down in the elevator, have Rummikub. My father said the best part of his day three times was chow time -- he was in the army, you know, whatever -- meeting everybody at dinner, breakfast, lunch and dinner and seeing what their aches and pains and day was like.

I could afford to live alone. I'll never live alone in a home, in a fabulous home with (inaudible) help. That's exactly the torture you're talking about. I'll go somewhere, whatever I can afford -- and I really don't care at that point because you're in a house dress in a f***ing wheelchair.

(Laughter)

SPEAKER: So, you know, saving here all day. Just make sure you have a place to go. They give you the pills. They give you the shot. You see this guy here and that women here. They can just about play Rummikub and remember what to put where.

MS. HAFNER: On that note --

SPEAKER: The point is --

(Laughter)

(Applause)

MR. HAFNER: I think you -- thank you. We have to end unfortunately, but you -- I think we're done.

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