The Health-Promoting Effects of Social Bonds

Linda K. George, Ph.D.

Department of Sociology

Center for the Study of Aging and Human Development

Duke University

Durham, NC

Contact Information

919-660-5605 phone

919-660-5623 fax

lkg@geri.duke.edu

One of the interesting aspects of investigating the effects of social factors and conditions on health is that most social factors are such taken-for-granted components of life that we often fail to recognize their power and potential. This is the case with social bonds. A quarter century of research consistently demonstrates the importance of social bonds for health and longevity at both the individual and population levels. New findings emerge consistently and, with proper research investments, will continue to be discovered.

In the brief time available to me today, I want to accomplish several tasks. First, I want to briefly discuss the nature of social bonds and the multiple levels at which they operate. Second, I will summarize, in general terms, what is known about the relationships between social bonds and health. Third, I will articulate the policy and intervention implications of what is known about social bonds and health. Finally, I will briefly address important aspects of the relationships between social ties and health for future research.

If there is any single activity that dominates human life, it is social interaction. We are born unable to care for ourselves, dependent on others. Everything that we learn during childhood and beyond is learned in interaction with others. Our adult lives are spent working with others, investing in relationships with family and friends, and participating in a variety of forms of civic engagement. During late life, we continue to focus on relationships and social interaction and after our deaths, the disposition of our estates generally reflects the social bonds we hope to keep strong even when we are not here. Probably no one disagree that social bonds are the very foundation of human life, but it is only recently that the powerful effects of social bonds on health and longevity have been demonstrated.

Social bonds take multiple forms. For our purposes, I will discuss two of those forms: social support and community engagement. Social support networks consist of those people with

whom we share intimate ties, typically family and friends. Social support consists of the broad range of goods and services exchanged by and available from social support networks. Both tangible and intangible forms of support are important. Tangible forms include the multitude of specific goods and services exchanged by family and friends – everything from assistance when we are sick, to babysitting, to transportation when we need it, to financial contributions. As important as tangible services are intangible components of social support: feeling cared about and for, having one's sense of self validated, feeling understood, and the sense that there are people with whom we can share our most intimate thoughts.

Community engagement takes place at a different level, referring to the ways in which we are embedded in community structures. It is still possible in some small towns and villages to experience a sense of community – that is, to share assumptions and goals, to feel valued and respected as a result of community membership, and to share identity. For most Americans, however, cultural complexity and mobility preclude a sense of community based primarily on place of residence. For most of us, our community engagement takes place in organizational structures – civic groups, voluntary organizations of all kinds, and, especially, religious communities.

Strong, high-quality research now demonstrates convincingly that social bonds at both levels promote physical health, mental health, and longevity. And this research meets strict criteria for making this kind of causal statement. These results are observed after taking into account every other predictor of health and longevity that is known and measurable. The sheer volume of research is larger for social support than for civic engagement. It is now clear that social support plays both a *preventative* and a *therapeutic* role in health. In terms of prevention,

social relationships have been demonstrated to decrease the likelihood of the onset of chronic disease, disability, mental illness, and death. Indeed, marital status alone is a powerful predictor of survival. Controlling on or taking into account every other risk factor for death that we know, including physical health status, rates of all-cause mortality are twice as high among the unmarried as the married. Additional health benefits result from parenthood, close relationships with siblings and other relatives, and close friendships. In addition to promoting health in a direct and straightforward manner, social support is a critical contingency in the effects of stress on health. The negative effects of both acute and chronic stressors on health are substantially reduced among persons with high levels of social support.

The therapeutic effects of social support are observed when investigators study the course and outcome of disease. This is a different population than that studied for purposes of identifying the preventative effects of social support. For purposes of studying prevention, we start with a basically healthy population and identify factors associated with the onset of new illnesses or mortality. For purposes of studying the therapeutic effects of social support, we start with a population that is already sick and identify factors associated with greater likelihood of recovery and/or shorter time till recovery. Again, strong evidence documents the fact that, taking into account a myriad of other risk factors, social support is associated with (a) greater likelihood of recovering from physical and mental illnesses, (b) shorter time till recovery, and (c) greater likelihood of survival for life-threatening conditions.

The preventative role of civic engagement also is well-documented. Participation in voluntary organizations, for example, has been shown to be a strong predictor of mortality over 30 subsequent years with other risk factors taken into account. Frequent attendance at religious

services has been observed to result in an average longevity advantage of eight years among a sample of older adults, again with other risk factors including physical and mental health taken into account. Similar, if somewhat less dramatic effects have been found for the onset of physical and mental illnesses.

Evidence about the therapeutic effects of civic engagement are less plentiful, but are tantalizing. The best evidence to date links attendance at religious services with the course and outcome of physical and mental illness. The few studies available indicate that a pre-illness pattern of frequent attendance at religious services is associated with both a greater likelihood of recovery or improvement in physical and mental illnesses and a quicker recovery or improvement. Research also has examined a variety of dimensions of religious involvement – not only attendance at services, but also frequency of private devotions, and religious commitment. Without exception, research to date has found that attendance at services is the strongest predictor of health outcomes, suggesting that it is something about the social or communal nature of service attendance that amplifies the effect of religious participation on health.

Thus far, my comments have been based on both research that simply quantifies the number of social bonds individuals have and studies that take into account the quality of those social bonds. Research that restricts analysis to social bonds that are perceived by individuals to be of high quality show even more dramatic results than those that do not take quality into account. More importantly, there is increasing evidence that poor-quality relationships can actually harm physical and mental health. Indeed, persons in unhappy marriages exhibit worse physical and, especially, mental health than unmarried persons. Similarly, individuals who report

frequent attendance at religious services, but describe their congregations as conflicted or unsupportive have worse health than persons who do not attend religious services. To date there is no evidence that poor-quality relationships increase the risk of mortality, but this is because this issue hasn't been studied, not as a result of negative findings.

There is a "flip-side" to research on social support. Just as supportive ties promote health and longevity, the loss of such relationships threaten health. This is observed most dramatically, perhaps, in research on marital dissolution. It is now well-established that, on average, widowed individuals are at increased risk of mental health problems, the onset or exacerbation of physical illness, and mortality for two years after the spouse's death, although the first six months are the period of highest risk. Divorce also often has negative health implications, especially if the individual did not initiate or desire the divorce. Separation and divorce place individuals at increased risk of mental health and substance abuse problems, although there is no evidence that physical health and longevity are seriously threatened. And it is sobering to note that, for women, even a stable remarriage does not totally eliminate excess psychiatric symptoms.

Unfortunately, to date, no research has investigated the health effects of the loss of sources of civic engagement. There is reason to expect that a higher proportion of decreases in civic easement represent the voluntary decisions of individuals than is the case for the loss of intimate ties. If this is true, the health effects of declines in civic engagement may be weak or even insignificant. On the other hand, there are undoubtedly circumstances in which the loss of civic ties is literally or functionally involuntary. Examples include persons who enter nursing homes and are no longer able to participate in their religious communities and persons whose failing health preclude civic engagement. In these cases, of course, declines in health will have

preceded the declines in civic engagement. It also is possible, however, that these processes feed each other such that declines in health lead to declines in civic engagement which, in turn, have additional disadvantages for health.

In short, although the research base is far from complete, there is ample evidence to permit the firm conclusion that high-quality social bonds have strong health-promoting and health-sustaining effects. This conclusion is true for both intimate ties and for community-based forms of civic engagement.

Implications for Policy and Intervention

Translating knowledge about the health-promoting effects of social bonds into forms that are usable for policy and intervention is less direct than is the case for many other risk factors for morbidity and mortality. Social bonds simply do not lend themselves to the more straightforward strategies of testing interventions. Conducting randomized clinical trials of smoking cessation programs and exercise regimens, for example, is a sensible enterprise. In contrast, it is difficult to imagine randomly assigning folks to supportive relationships or even to skills training in social relationships. Social bonds tend to develop naturally and they require considerable time before the ties of affection and commitment are firmly established. Despite these problems, there are a variety of ways that research on social bonds has intervention and, especially, policy relevance.

Most importantly, policies at all levels should be examined to determine if they threaten existing social bonds. In general, policies that unwittingly weaken family/friend ties and community bonds will indirectly threaten health. Policies that unwittingly force mothers to leave children in unsupervised situations are certain to strain family ties. At a more local level, policies that result in children having to change schools (e.g., because of redistricting) will

weaken children's ties to their peers and communities. Policies that threaten the mission of civic organizations will weaken community-based civic bonds. Allowing the free market to result in dislocation of neighborhood residents will weaken social bonds and, perhaps, health as well. Even health policies that operate to destroy continuity of care may contribute in their own way to increased risk of disease. In general, policies should follow the medical dictum, "at least do no harm," and policy makers should be sensitive to the fact that one form of harm is the weakening of social bonds.

Social bonds also are relevant to interventions in both general and specific ways. At the general level, involving support networks in attempts to change attitudes, knowledge, and behavior is a useful idea. Given what we know about the critical importance of the quality of social bonds, clinicians and practitioners should not naively assume that a spouse, parent, or child will be a source of support. But identification of high-quality social bonds can increase the leverage of intervention programs. Also at a general level, better understanding of the ways that losses of social bonds can threaten health can be useful for targeting interventions. Nearly any program that targets the socially isolated as one key consumer group will be serving a group at increased risk of health problems. At a somewhat broader level, community-targeted interventions should not occur until pre-existing community-based bonds and organizations have been identified and "brought on board." Involvement of pre-existing social bonds will increase the likelihood of intervention success and insure that those bonds are not inadvertently weakened as a result of the intervention. Along those same lines, effective civic groups that accomplish public interest goals and/or strengthen community ties should be recognized, praised, and, perhaps, rewarded. I am not as sanguine about direct public funding of community

organizations, as has been proposed for faith-based communities. My fear is not that the funds would be misused or squandered. Instead, my fear is that government agencies would be unable to resist placing such regulations and constraints on the organizations that their communal strengths would erode. I do not, in short, want to see community organizations sell their souls to do "good" as that is defined and dictated by external agencies.

What about interventions to help individuals develop the qualities that will permit them to form effective social bonds? I am largely pessimistic on that front. I am aware that a large proportion of the programs being tested on "at risk" children involve social skills as well as disciplinary interventions, enriched academic curricula, and so forth. I also am aware that many of these intervention programs include working with parents on both "parenting skills" and specific ways to support the goals of the intervention effort. There is a good chance, I think, that such programs may, in fact, strengthen children's social skills and parent-child bonds. Beyond this, however, I am pessimistic. I simply cannot see an intervention program designed to teach widowed older adults the social skills to develop new social networks as being effective or palatable to the intended consumers. In contrast, policies (as opposed to interventions) that make it easier for individuals to meet and feel safe in the presence of persons with similar social characteristics will indirectly nurture the development of social bonds. As has been repeatedly demonstrated, this almost always happens in low-income public housing facilities for the elderly.

Finally, with regard to intervention and policy, a word about support groups may be in order. There is reasonably strong evidence that support groups offer some people a kind of social bond that is largely unavailable in other settings. Many individuals benefit from regular interaction, sustained over time, with people who share a specific status or situation. Research to

date, however, also suggests a number of conditions and caveats regarding the effectiveness of support groups. First and most important, even long-running, well-attended support groups experience (a) the inability to recruit many potential participants and (b) high drop-out rates. Support groups simply are not palatable to many individuals; consequently, they are not universally applicable or effective. Second, support group members are most satisfied, learn more, and so forth when they attend meetings over a significant period of time. Apparently a substantial time commitment is required before support groups translate social interaction into social bonds. Third, support groups are most effective for members who begin their participation prior to a crisis – a medical or other crisis is not conducive to developing high-quality social bonds. Fourth and finally, support groups are most effective when there is a professional leader (e.g., a clinician who specializes in common issue faced by the group or a professional trained in group dynamics). The leader may be a volunteer and/or may be confronting the issue that is the common concern of the group, but professional leadership is a common element of effective and self-sustaining support groups. Thus, I view support groups as one option for developing effective social bonds – but an option that will not have wide-spread appeal to consumers.

Opportunities for Future Research

There is much yet to be learned about social bonds, their effects on health, and especially the social conditions that strengthen and weaken them. Research to date makes it clear that, like economic resources, education, and other resources, social bonds are stratified in our society. They are distributed unequally and non-randomly and those patterns are closely linked to health and longevity. Consequently, the research base needs to be broadened.

One high priority topic is to increase our understanding of variability in social bonds.

What are the conditions that permit some individuals to develop and sustain high-quality bonds, while others can not? In what ways do social change foster social bonds? Conversely, in what ways does it threaten them? Multidisciplinary research will be required to adequately address these issues. Clearly social factors will not explain all the variability, although it will explain some of it. Psychological factors are clearly implicated and it is possible that biological factors are as well.

Research on civic engagement lags significantly behind that on social support and more intimate ties. More effort is needed to better understand how and why our broader connections to social institutions promote health. Early evidence suggests that the mechanisms are significantly different from those that link social support to health. For example, it appears that access to sources of information not available from social support networks is an important and distinctive element of participation in organizational communities. But substantially more effort is needed.

As a final illustration, research also is badly needed that links social support and civic engagement. Does civic engagement foster social support networks, complementing their strengths? Do social support networks vary in the extent to which they tolerate civic engagement by members?

Social bonds are the nexus of human life and societies. They transmit cultural knowledge and are the vehicle by which social change occurs. They are intertwined with health and longevity from birth to death. Their ubiquitous nature should strengthen our commitment to understand and nourish them. This is a priority for human well-being and public health.