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Citation

Published Version
doi:10.1016/j.pmedr.2018.01.013

Citable link
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Social integration and healthy aging among U.S. women

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Contents lists available at ScienceDirect

Preventive Medicine Reports

journal homepage: www.elsevier.com/locate/pmedr

ARTICLE INFO

Keywords:
Social integration
Healthy aging
Chronic disease

ABSTRACT

Background: Social integration has been related to risk of chronic diseases and mental health conditions. Purpose: We investigated the association between social integration in midlife with subsequent health and well-being in aging.

Methods: We included women from the Nurses’ Health Study in the United States, who had no major chronic diseases in 1996 when we assessed social integration, using the Berkman-Syme Social Network Index. We defined healthy aging after 16 years of follow-up, when women ranged from 66 to 91 years, on the basis of survival along with 4 health criteria, assessed in 2012: no history of major chronic disease diagnosis, no self-reported impairment in memory, and no major impairments in physical function or mental health.

Results: Of the 41,013 surviving participants in 2012 with information on social integration and health criteria, 6206 (15.1%) were healthy agers (i.e., met all four criteria) and the remaining 34,807 (84.9%) were usual agers. After multivariable adjustment, women who were socially integrated at midlife had modestly better odds (odds ratio = 1.38, 95% confidence interval: 1.23, 1.55) of healthy aging compared to women who were socially isolated.

Conclusions: In this study, we found that women who were more socially integrated were more likely to be healthy agers. The results provide evidence for a longitudinal association between social integration and healthy aging.

1. Introduction

As the proportion of the U.S. population 65 years and older continues to grow (Centers for Disease Control and Prevention, 2013), identifying factors that contribute to healthy aging are of increasing importance. Midlife factors likely contribute to many chronic health conditions that manifest during older age. Social integration is one such factor that may have a significant impact on both physical and mental health in later life (Berkman et al., 2000). Prior studies have suggested that increased social integration associated with better physiological function (Yang et al., 2016), reduced risk of chronic diseases (Crittenden et al., 2014; Yang et al., 2016), dementia (Kuiper et al., 2015), and mortality (Barger, 2013). Social integration includes marital status, contact with relatives and friends, religious service attendance, as well as community activities (Berkman and Syme, 1979). These individual components could each be related to healthy aging; for example, prior evidence has indicated that religious service attendance is associated with better physical and psychological health (Powell et al., 2003; Hackney and Sanders, 2001). Additionally, a recent study found that frequent attendance at religious services was associated with lower risk of all-cause, cardiovascular, and cancer mortality (Li et al., 2016). Thus, we investigated the associations between social integration in midlife with subsequent healthy aging, a composite outcome including survival as well as self-reported measures of chronic disease, impairments in memory, physical function, and mental health, among women in the Nurses’ Health Study.

2. Methods

2.1. Study population

The Nurses’ Health Study began in 1976 when 121,700 U.S. married women aged 30 to 55 years completed a mailed questionnaire. Follow-up questionnaires were sent every 2 years and follow-up remains completed for > 90%. In 1992 and every four years thereafter, the Medical Outcomes Study Short-Form-36, a 36 item-questionnaire which evaluates eight health concepts (including mental health and physical functioning) was administered (Ware, 1993). In 2012, questions were...
added that addressed subjective memory concerns. This study was approved by the Institutional Review Board of Brigham and Women’s Hospital (Boston, MA).

2.2. Ascertainment of social integration

Social integration was measured by the Berkman-Syme Social Network Index (Berkman and Syme, 1979), a composite measure of four types of social connection: marital status (married versus not); sociability (number and frequency of contact with children, close relatives, and close friends); church group membership (yes versus no); and membership in other community organizations (yes versus no). Responses to the Social Network Index were categorized into four levels of social connection: socially isolated (individuals with low intimate contacts— not married, fewer than six friends or relatives, and no membership in either church or community groups), moderately isolated, moderately integrated, and socially integrated (Kawachi et al., 1996). We defined baseline in this analysis as social integration as assessed in the 1996 questionnaire (the Berkman-Syme Social Network Index = 1 for socially isolated, 2–5 for moderately isolated, 6–7 for moderately integrated, 8–12 for socially integrated). See the Online Supplement for further details of the calculation.

2.3. Ascertainment of healthy aging

We separated “healthy” from “usual” aging on the basis of survival as well as 4 health domains measured in 2012. We considered persons free of 11 chronic diseases, with no reported memory impairment, no physical disabilities, and intact mental health as healthy agers; remaining women were usual agers.

Incidence of 11 chronic diseases was reported on the biennial questionnaires (Colditz et al., 1995; Barr et al., 2002; Alonso et al., 2008; Sun et al., 2007). This list combined primary causes of death in the United States (cancer other than non-melanoma skin cancer, myocardial infarction, coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, congestive heart failure, and stroke) and diseases commonly found in the literature on healthy aging (type 2 diabetes, kidney failure, chronic obstructive pulmonary disease, Parkinson disease, multiple sclerosis, and amyotrophic lateral sclerosis). To avoid redundancy, we did not include diseases that were reflected by other components of our healthy aging outcome (for example, dementia was not one of the chronic diseases considered because subjective memory concerns were a separate domain).

Subjective memory complaints were assessed through a set of 7 yes/no questions from the 2012 biennial questionnaire. These questions were based on a prior study that used these same questions to detect subjective memory concerns. This study was applied, moderately integrated, and socially integrated (Kawachi et al., 1996). We defined baseline in this analysis as social integration as assessed in the 1996 questionnaire (the Berkman-Syme Social Network Index = 1 for socially isolated, 2–5 for moderately isolated, 6–7 for moderately integrated, 8–12 for socially integrated). See the Online Supplement for further details of the calculation.

2.4. Ascertainment of covariates

Sociodemographic, lifestyle and health-related covariates (age; smoking; body mass index; physical activity; alcohol consumption; diet quality; husband’s education; hypertension, hypercholesterolemia, physical exam in the past two years; post-menopausal hormone use) were obtained from the 1996 biennial questionnaire. Median annual household income and home value were estimated from the census tract of participant’s residence, geocoded to the 1994 U.S. Census.

2.5. Population for analysis

Among 100,952 women who returned their 1996 questionnaire, 14,224 were excluded because of missing information on social integration. An additional 21,876 women were excluded because they had reported a history of any of the 11 chronic diseases as of 1996. We excluded 23,839 women missing the healthy aging outcome due to an incomplete Medical Outcomes Study Short-Form-36, skipping any items on the Geriatric Depression Scale-15, skipping > 5 items on the physical function scale, or the missing responses to the questions on subjective memory complaints on the 2012 questionnaire. Thus, we had 41,013 participants available for analyses.

2.6. Statistical analysis

To evaluate the association between social integration in midlife and healthy aging, we used age-adjusted and multivariable-adjusted logistic regression models. Sociodemographic, lifestyle, and health-related covariates were obtained from the 1996 questionnaire. We also secondarily conducted analyses in which we examined the individual components of the social integration score (marital status, religious service attendance, membership in other community organizations, and sociability level). When considering the individual components, all components were included in models simultaneously and multivariable models were adjusted for the same confounders as in the main analysis. In sensitivity analyses, we considered social integration in 2000, 2004, and 2008 in relation to healthy aging in 2012; these were not primary analyses since we were concerned that as the women aged, their level of social integration may become increasingly linked with their underlying health, possibly leading to reverse causation bias. We used sensitivity analysis for unmeasured confounding to assess the robustness of our results to uncontrolled and residual confounding (Ding and VanderWeele, 2016).

3. Results

Compared to women who were socially isolated at midlife, women who were socially integrated (Table 1) tended to drink less, were more physical active, were less likely to be current smokers, were more likely to be not employed outside the home or retired, were more likely to have a physical exam in the past two years, and their husbands tended to have a higher education level. The groups were similar in terms of body mass index, diet quality, median family income, and prevalence of hypertension and high cholesterol.

Of the 41,013 participants, 6206 (15.1%) were considered healthy agers and the remaining 34,807 (84.9%) were considered usual agers. In age-adjusted analyses of social integration at midlife and subsequent odds of healthy aging, women who were socially integrated had 48% higher odds (odds ratio (OR) = 1.48, 95% confidence interval (CI): 1.33, 1.65) of healthy aging compared to women who were socially isolated at midlife. After adjusting for potential confounders, results were attenuated but remained significant (multivariable-adjusted OR comparing socially integrated vs. socially isolated = 1.34, 95% CI: 1.18, 1.51, Table 2). In sensitivity analysis for unmeasured confounding, an unmeasured confounder that was associated with both social integration and healthy aging by a risk ratio of 2.01-fold each could explain away the estimate, but weaker confounding could not; to shift the confidence interval to include the null, an unmeasured confounder that was associated with social integration and healthy aging by a risk ratio of 1.64 each could do so, but weaker confounding could not.
Abbreviations: MET, metabolic equivalent of task; AHEI, Alternative Healthy Eating Index.

We also ascertained relations of specific components of the social integration score with healthy aging (Table 3). In multivariable models including all the components simultaneously, we found that sociability level was significantly related to healthy aging (OR comparing high vs. low sociability level was signiﬁcant positive association between social integration and healthy aging. The results were moderately robust after multivariable adjustment, as well as in sensitivity analysis. We provided some evidence for modest associations between social integration with healthy aging, adding to the already documented relations reported for other more specific dimensions of health (Berkman et al., 2000; Crittenden et al., 2014; Yang et al., 2016; Kuiper et al., 2015; Barger, 2013).

We are currently living in a world that is rapidly aging. According to the United Nations 2015 report, 13% of the global population was over 60 years in the year of 2015, and by the year of 2040 it will increase to approximately 2.1 billion people. The elderly are at an increased risk of social isolation because of physical functional deﬁcits that prevent social participation, lack of access to adequate transportation, and the loss of formal social roles and meaningful interpersonal connections (Barger, 2013; Berkman and Syme, 1979; Powell et al., 2003). With aging, people might also have a sense of limited time and therefore choose to maintain or strengthen their relations with family and intimate friends, while withdrawing from interactions with peripheral acquaintances (Yang et al., 2016).

As a sensitivity analysis we also assessed associations between social integration in 2000, 2004 and 2008, in relation to healthy aging in 2012 (Supplementary Table 1–3). The multivariable adjusted OR (95% CI) for healthy aging comparing those who were socially integrated to those who were socially isolated in 2000 was 1.43 (1.24, 1.65); in 2004: 1.65 (1.41, 1.95); and 2008: 1.48 (1.27, 1.72).

4. Discussion

In this study, we observed a signiﬁcant positive association between social integration and healthy aging. The results were moderately robust after multivariable adjustment, as well as in sensitivity analysis. We provided some evidence for modest associations between social integration with healthy aging, adding to the already documented relations reported for other more speciﬁc dimensions of health (Berkman et al., 2000; Crittenden et al., 2014; Yang et al., 2016; Kuiper et al., 2015; Barger, 2013).

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The association and underlying mechanisms through which social integration affect healthy aging have been analyzed based a cascading causal model started with the macro-social level down to

### Table 1
Age-adjusted baseline characteristics in 1996 of women in the Nurses’ Health study in the United States by categories of social integration.

<table>
<thead>
<tr>
<th>Socially integrated in 1996</th>
<th>Socially isolated (n = 3590), %b</th>
<th>Moderately isolated (n = 12,185), %b</th>
<th>Moderately integrated (n = 6477), %b</th>
<th>Socially integrated (n = 18,761), %b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>97</td>
<td>97</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>Education</td>
<td>Registered nurse</td>
<td>66</td>
<td>66</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Bachelor’s</td>
<td>22</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Master’s/doctoral</td>
<td>12</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Not employed outside the home or</td>
<td>39</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Smoking status</td>
<td>Never</td>
<td>37</td>
<td>43</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Former</td>
<td>44</td>
<td>45</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Current</td>
<td>19</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Current post-menopausal hormone</td>
<td>16</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Physical exam in the past 2 years</td>
<td>85</td>
<td>88</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td>33</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>High cholesterol</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Age, yearsc,d</td>
<td>59.2 (6.2)</td>
<td>60.2 (6.6)</td>
<td>60.0 (6.2)</td>
</tr>
<tr>
<td></td>
<td>Body mass indexc,e</td>
<td>26.4 (5.3)</td>
<td>26.3 (5.0)</td>
<td>26.2 (4.9)</td>
</tr>
<tr>
<td></td>
<td>Physical activity, METs/wk‡</td>
<td>16.9 (20.5)</td>
<td>18.8 (22.6)</td>
<td>19.5 (22.2)</td>
</tr>
<tr>
<td></td>
<td>Alcohol intake, g/day†</td>
<td>6.1 (10.3)</td>
<td>5.3 (9.0)</td>
<td>5.7 (8.9)</td>
</tr>
<tr>
<td></td>
<td>AHEI score†</td>
<td>53.2 (11.0)</td>
<td>53.2 (10.6)</td>
<td>53.8 (10.6)</td>
</tr>
<tr>
<td></td>
<td>Family income, dollars/yearc</td>
<td>66,972 (26,020)</td>
<td>66,948 (26,122)</td>
<td>68,421 (27,249)</td>
</tr>
<tr>
<td></td>
<td>1994 tract median house valued</td>
<td>193,500 (147,327)</td>
<td>183,538 (135,895)</td>
<td>190,315 (146,090)</td>
</tr>
</tbody>
</table>

Abbreviations: MET, metabolic equivalent of task; AHEI, Alternative Healthy Eating Index.

a Social Integration was measured using the Berkman-Syme Social Network Index.
b Values of polytomous variables may not sum to 100% because of rounding.
c Values are expressed as mean (standard deviation).
d Value is not adjusted for age.
e Weight (kg)/height (m)².

### Table 2
ORs (95% CIs) of healthy aging, according to categories of social integration in 1996 (n = 41,013).

<table>
<thead>
<tr>
<th>Socially integrated in 1996</th>
<th>Socially isolated</th>
<th>Moderately isolated</th>
<th>Moderately integrated</th>
<th>Socially integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy agers</td>
<td>466</td>
<td>1655</td>
<td>1605</td>
<td>3020</td>
</tr>
<tr>
<td>Age-adjusted OR</td>
<td>Reference</td>
<td>1.17 (1.04, 1.18)</td>
<td>1.48 (1.31, 1.67)</td>
<td>1.48 (1.33, 1.65)</td>
</tr>
<tr>
<td>(95% CI)</td>
<td>1.31 (1.20, 1.44)</td>
<td>1.65 (1.47, 1.85)</td>
<td>1.65 (1.45, 1.89)</td>
<td>1.65 (1.45, 1.89)</td>
</tr>
<tr>
<td>Multivariable-adjusted OR</td>
<td>Reference</td>
<td>1.09 (0.97, 1.18)</td>
<td>1.33 (1.16, 1.54)</td>
<td>1.34 (1.18, 1.54)</td>
</tr>
<tr>
<td>(95% CI)</td>
<td>1.23 (1.09, 1.40)</td>
<td>1.51 (1.34, 1.70)</td>
<td>1.51 (1.35, 1.70)</td>
<td>1.51 (1.35, 1.70)</td>
</tr>
</tbody>
</table>

a Adjusted for age (continuous), smoking (never, past, current), body mass index (continuous), physical activity (continuous), alcohol consumption, diet quality, Nurses’ education (RN, BA, or MA/DR), husband’s education (< high school, some high school, high school grade, college, graduate school), median family income, hypertension (yes/no), high cholesterol (yes/no), physical exam in the past 2 years (yes/no), post-menopausal hormone use (never, past, current), religious service attendance in 1992.
psychobiological pathways that are simultaneously and dynamically connected each other (Crittenden et al., 2014). Berkman proposed that the social network operate at the behavioral level through four main pathways: 1) provision of social support; 2) social influence; 3) on social engagement and attachment; 4) access to resources and material goods (Berkman et al., 2000). Neither networks nor social support are evenly dispersed throughout people’s social environments. Social resources clustered together in social institutions tend to make up of different nonintersecting networks and therefore o...

Conflict of interest

The authors declare there is no conflict of interest.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.pmedr.2018.01.013.

References

Ware, J.E., 1993. SF-36 Health Survey: Manual and Interpretation Guide. The Health Institute, New England Mediical Center, Boston.