

# Aging In Grace and the Effects of Social Isolation on the Elderly Population



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## Abstract

Our conception, birth and developmental processes are as a result of human cooperation which establishes a necessity of our dependence on others for success, personal progress and well-being. Without this cooperation our full growth into adulthood will be grossly hampered. This article will discuss such cooperation and confirm the reality that we are summed by the contributions made in our lives by people we have been privileged to encounter in our journey of life.

It identifies successful aging or aging in grace within a framework of factors and conditions that encourage the potential development of the 'untapped reserves' of the elderly population. It also aims at demonstrating how social isolation is a problem in the general well-being of the elderly population and "social death" as a devaluation of the humanity of others and of the human person in general. Finally, it recommends social support systems as imperative in promoting general well-being among older adults.

## Introduction

In the light of our collective cynicism and stereotyping of aging and the elderly—elderly people are sick, elderly people are ugly, elderly people are obsolete, the question arises: is there any hope to age in grace or successfully, and experience some kind of tranquility and happiness in the process, and what would that entail? Aging in grace, graceful aging, successful aging, optimal aging, positive aging, productive aging, active aging, adaptive aging, or aging well, are all ideas without universally accepted definitions. A focus on aging includes concepts such as health, life satisfaction and quality of life and genetic, biomedical, behavioral and social factors.

## Aging in Grace and Other Nuances

The terms aging in grace, graceful, successful, positive or optimal aging are usually used interchangeably, but, according to many gerontologists these terms focus on life-style choices that promote quality aging, and therefore minimize age-related problem. The term successful aging was made popular by Rowe and Kahn [1] in order to describe quality aging well into old age. Aging in grace is one of the ways of describing the other ways of growing old happily, successfully and normally, or the average aging development as assessed on any measure and with any age definition, and pathological aging, which incorporates acute or chronic disease that hampers a normal aging pattern and

accelerates decline. Many people, view aging as 'something to be denied or concealed', but aging in grace and successful aging have to do with 'aging well' which is not the same as 'not aging at all'.

Successful aging is no longer an oxymoron but a reality. Nevertheless, a standard or uniform definition for successful aging still does not exist. Part of the problem in defining the term is a lack of consensus on what aging is, when it starts, and finding general criteria for success, since social and cultural values both play a role in the definitions [2]. Successful aging can be defined as the process of promoting gains and preventing losses through a process called 'Selection, Optimization and Compensation' (SOC). An inclusive definition of successful aging necessitates a value-based, systemic, and an ecological perspective. Both subjective and objective indicators need to be considered within a given cultural context with its particular contents and ecological demands. The solution according to Rowe and Kahn [1] is thus to use various subjective and objective criteria for successful aging, focusing on individual variability within a given culture.

Successful aging is the result of the interaction between an aging individual within his or her society over the life span, and can also be described as the process of 'adaptive competence'

with regard to the challenges of later life, using both internal and external resources. Since dynamics in society influence the aging process, successful aging is not solely an inherent quality of an aging person. There is a bidirectional relationship between an aging individual's adaptive competence and the developmental tasks of society. Successful agers appear to fare well on developmental tasks. There does not seem to be clear scientific agreement on a definition of developmental tasks, but Featherman et al. [3] describe them as sequences of tasks over the life course whose satisfactory performance not only is important for the person's sense of competence and esteem in the community, but also serves as preparation for the future. Developmental tasks require using one's cognitive, emotional and behavioral skills to manage one's life circumstances. Examples of adaptive competence include gathering social support, maintaining independence as far as possible and adjusting well to retirement. Featherman et al. [3] are of the opinion that as aging progresses, ill-structured tasks outnumber well-structured tasks. Well-structured tasks are sometimes defined as problems with standard solutions or techniques, and ill-structured tasks as more ambiguous problems with relative solutions. Reflective planners tend to fare better in retirement because of their accumulated expertise in solving ill-structured problems.

### I. With Rowe and Kahn, we identify three key aspects in successful aging

- i. preventing disease and disability as far as possible, inter alia through good lifestyle choices,
- ii. continuing with mental and physical exercise throughout the life span, and
- iii. Keeping up an active life-style, by being productive and by fostering strong social relationships.

This identification was based on the 10-year MacArthur study involving a multi-disciplinary team of professionals that wanted to answer three questions:

- i. the meaning of successful aging,
- ii. what can be done to age successfully, and
- iii. What changes are necessary in American society to facilitate successful aging.

This equally helped with a paradigm shift away from conceptualizing aging as more focused on disease and disability, to a more hopeful approach. However, research confirms that few very old people (older than 90 years) age successfully. Thus, the concept aging in grace, Ihenetu [2] suggests is more 'comprehensive' than successful aging, because aging in grace focuses on 'quality of life and a sense of well-being' despite age-related decline or ill health. Successful aging for some researchers is an idealized term that is not necessarily in accordance with the present reality of aging, due to the fact that restrictive

factors such as ageism, affordable housing, adequate income and quality healthcare are not taken into consideration. On the other hand, the value of successful aging lies in understanding that an individual can contribute to aging well, for example through specific activities or life-style choices. Nevertheless, few elderly people fit neatly into the categories of successful, normal or pathological aging for all capabilities and suggests that one should maximize successful aging in the capabilities one can control as early in life as possible, employing preventive measures to delay age-related decline for as long as possible.

### Social Death and Social Isolation Among The Elderly Population

With the advance of science and modernity, the meaning and understanding of death has been evolving. Death can be defined on a variety of different levels but most people define death as a physical event in which there is a cessation of all bodily functions including beating of the heart. Some in the medical field will broaden this to include 'clinical' or 'biological' death. The 'social death' phrase evolved and relates to those who die in a social sense consequent to degeneration of the brain or disease, which limits interaction with those around them.

The first available presentation of social death came from Glaser and Strauss (1966), during a discussion of 'hopelessly comatose' patients, these authors describe their receipt of 'non-person treatment from hospital personnel when talking freely about things that would matter to the conscious patient. They said that socially he is already dead, though his body remains biologically alive. They also describe some 'senile patients' as 'socially dead as if they were hopelessly comatose' in the eyes of the families who consign them to institutions and thereafter fail to visit. Some individuals according to Ihenetu [4] regard certain health challenges as a result illness or old age as a social death in which the person is no more connected to society and is dying a little at a time with no hope for recovery. A person's true worth does not diminish as a result of certain health challenges, it becomes an assault for a system of society to diminish and devalue the humanity of others as socially dead or insignificant based on the condition of life.

It is important to debate the idea as to whether elderly persons who are faced with the challenges of old age can be considered socially dead because how they are perceived would directly correspond to how they are cared for and valued in society. A good place to start would be to ask the question; what is it that makes an individual into a whole person? What is it that would allow one to say that an individual has a worthwhile life or life of value? The perception of social death may have some correlation to anticipatory grief that precedes the impending death of an elderly patient. What this means is that the caregiver or family member who is in the position of contributing to the social life of the individual might have given up long before exhausting every available opportunity to communicate. Labeling someone

as socially dead is a serious allegation. In essence, it is the end of an individual's social existence. It might even be considered as a self-fulfilling prophecy that could speed up actual physical death. Social death occurs when a person is treated as a corpse although he or she is still clinically and biologically alive. For instance, this is much like allowing someone who was brought into a hospital in a near death state to remain on the stretcher overnight for the fear of unnecessarily having to dirty a bed. Social death does not always lead to biological death nor is it a definite concept.

A survey by Pat Robertson (2011) which referred to Alzheimer's patients as socially dead, 100% of the responses received from surveys sent out to caregivers show otherwise. When specifically asked if those with Alzheimer's are to be considered socially dead, here below are some of the responses received from caregivers: "Absolutely not; each time my father saw me I could see a twinkle in his sad blue eyes. He did not know my name but he called me pretty". Another said, "Not at all – we still can enjoy church; sing and he still goes to Sunday school but does not recall anything except the Lord's Prayer". To the same question, a Hospice Medical Director writes "No, because they are still relational to the family to which they belong. They interact with loved ones even until death." Another doctor who specializes in geriatrics notes, "In those with advanced dementia though the interaction/conversation may be basic or repetitive, they can still interact and thus are not socially dead." A palliative care doctor said, "I believe they are far from socially dead. Although they may not be able to verbalize, they do communicate in other ways – why can't people see it?"

Self-perceived social death occurs when an individual accepts the notion that he or she is as good as dead. When a patient is given a terminal diagnosis, it can be a cause to precipitate such thought. However Kastenbaum [5] is of the view that social death must be defined situationally. In particular, it is a situation in which there is absence of those behaviors which we would expect to be directed towards a living person and the presence of behaviors we would expect when dealing with a deceased or non-existent person. Thus, although an individual may be potentially responsive and desperately seeking recognition and interaction, that individual will by this definition be socially dead if others cease to acknowledge his or her continued existence. Consequently, it is paramount to get this right. Non-cognitive or elderly persons should never be looked upon as those who cease to have continued existence [4].

On the other hand, when we look at social isolation among elderly adults, we discover that there are so many researches on the effects of isolation on children and young adults, but only a few on the effect of isolation on the elderly. However, the human need for social connection does not fade away among the elderly, which is to say, the elderly have the need for social connections. Decline of social connection is considered one of the various interrelated factors which compose well-being among the

elderly. Hence, it is necessary and important to deepen the knowledge about social isolation among the elderly. According to some authors, social isolation is a subject concerned with the objective characteristics of a situation and refers to the absence of relationships with other people, that is to say, they believe that persons with a very small number of meaningful ties are socially isolated, (ibid.,35).

Meanwhile, Ihenetu [4] enumerated five attributes of social isolation as: number of contacts, feeling of belonging, fulfilling relationships, engagement and quality of network members. Consequently, even loneliness, depression symptoms and their temporal connection are not attributes of social isolation, but those concepts can be causes of being socially isolated. Therefore, lack of a sense of social belonging, lack of social contacts, lack of fulfilling and quality relationships, psychological barriers, physical barriers, low financial/resource exchange and a prohibitive environment can be possible reasons leading to social isolation.

Turning to the effects of being socially isolated, it has been associated with increased vascular resistance, elevated blood pressure, impaired sleep, altered immunity, alcoholism, progression of dementia, obesity and poorer physical health. In other words, socially isolated individuals have a higher possibility of suffering from health issues. Also, drinking, falls, depressive symptoms, cognitive decline and poor outcome after stroke, nutritional risk, increased rates of re-hospitalization, loneliness and alteration in the family process were also specific effects of social isolation. These truly existing negative effects prove that social isolation has a far-reaching impact on elderly well-being.

Its effects on the elderly well-being are phenomena which cannot be ignored. The socially isolated elderly persons are among the risk group for myriad other negative health consequences, such as poor nutrition, cognitive decline and heavy alcohol consumption. Therefore, social isolation has a non-ignorable influence on elderly well-being [4]. It is more prevalent in older adults due to diminished vitality and health. In other words, diminished vitality and health are direct causes for being socially isolated among the elderly. Simultaneously, vitality and health are considered a vital dimension of elderly well-being. In sum, the relevance between elderly well-being and isolation is arising from interaction.

## Isolation

### A Working Definition

'Belonging' is a multi-dimensional social construct of relatedness to persons, places, or things, and is fundamental to personality and social well-being. If belonging is connectedness, then social isolation is the distancing of an individual, psychologically or physically, or both, from his or her network of desired or needed relationships with other persons. Therefore, social isolation is a loss of place within one's group(s). The

isolation may be voluntary or involuntary. In cognitively intact persons, social isolation can be identified as such by the isolate.

Some researches portray social isolation as typically accompanied by feelings related to loss or marginality. Apartness or aloneness, often described as solitude, may also be a part of the concept of social isolation, in that it is a distancing from one's network, but this state may be accompanied by more positive feelings and is often voluntarily initiated by the isolate. Some researchers debate whether apartness should be included in, or distinguished as a separate concept from, social isolation. Social isolation as we can see has several definitions and distinctions, dependent upon empirical research and the stance of the observer.

### When Isolation Becomes A Problem

Social isolation ranges from the voluntary isolate who seeks disengagement from social intercourse for a variety of reasons, to those whose isolation is involuntary or imposed by others. Privacy or being alone, if actively chosen, has the potential for enhancing the human psyche. On the other hand, involuntary social isolation occurs when an individual's demand for social contacts or communications exceeds the human or situational capability of others. Involuntary isolation is negatively viewed because the outcomes are the dissolution of social exchanges and the support they provide for the individual or their support system(s). Some persons, such as those with cognitive deficits, may not understand their involuntary isolation, but their parent, spouse, or significant other may indeed understand that involuntary social isolation can have a negative and profound impact on the caregiver and care recipient.

When social isolation is experienced negatively by an individual or his or her significant other, it becomes a problem that requires management. In fact, according to much of the literature, only physical functional disability ranks with social isolation in its impact on the patient and the patient's social support network (family, friends, fellow workers, and so forth). Therefore, social isolation is one of the two most important aspects of chronic illness to be managed in the plan of care.

### The Nature and Distinctions of Social Isolation

Social isolation is viewed from the perspective of the number, frequency, and quality of contacts; the longevity or durability of these contacts; and the negativism attributed to the isolation felt by the individual involved. Social isolation has been the subject of the humanities for hundreds of years. Who has not heard of John Donne's exclamation, 'No man is an island', or, conversely, the philosophy of existentialism—that humans are ultimately alone? Yet the concept of social isolation has been systematically researched during only the last 50 years. Unlike some existentialists and social scientists, healthcare professionals, with their problem-oriented, clinical approach, tend to regard social isolation as negative rather than positive, (ibid.). However, isolation can occur at four layers of the

social concept. The outermost social layer is community, where one feels integrated or isolated from the larger social structure. Next is the layer of organization (work, schools, churches), followed by a layer closer to the person, that is, confidantes (friends, family, significant others). Finally, the innermost layer is that of the person, who has the personality, the intellectual ability, or the senses with which to apprehend and interpret relationships.

In the healthcare literature, the primary focus is on the clinical dyad, so the examination of social isolation tends to be confined to the levels of confidante and person, and extended only to the organization and community for single clients, one at a time. For the healthcare professional, the most likely relationships are bound to expectations of individually centered reciprocity, mutuality, caring, and responsibility. On the other hand, health policy literature tends to focus on the reciprocity of community and organizations to populations of individuals, and so it deals with collective social isolation. At the level of the clinical dyad, four patterns of social isolation or interaction have been identified; although these were originally formulated with older adults in mind, they can be analogized easily to younger persons by making them age-relative:

- Persons who have been integrated into social groups throughout their lifetime.
- The 'early isolate' which was isolated as an adult but is relatively active in old age
- The 'recent isolate' who was active' in early adulthood but is not in old age.
- The 'lifelong isolate' whose life' is one of isolation.

Normally there are feelings that isolation brings which are often characterized by boredom and marginality or exclusion. Boredom occurs because of the lack validation of one's work or daily routines; therefore, these tasks become only busy work. Marginality is the sense of being excluded from desired networks or groups. Other feelings ascribed to social isolation include loneliness, anger, despair, sadness, frustration, or, in some cases, relief.

### Progressions In Social Isolation

Regardless of how social isolation occurs, the result is that basic needs for authentic intimacy remain unmet. Typically this is perceived as alienating or unpleasant, and the social isolation that occurs can lead to depression, loneliness, or other social and cognitive impairments that then exacerbate the isolation. Several predisposing reasons for social isolation have been proposed: status-altering physical disabilities or illnesses; frailties associated with advanced age or developmental delays; personality or neurologic disorders; and environmental constraints, which often refer to physical surroundings but are also interpreted by some to include diminished personal or material resources.



A typical course of isolation that evolves as an illness or disability becomes more apparent is the change in social network relationships. Friends or families begin to withdraw from the isolated individual or the individual from them. This process may be slow or subtle, as with individuals with arthritis, or it may be rapid, as with the person with AIDS. Unfortunately, the process of isolation may not be based on accurate or rational information. Individuals with serious chronic illnesses come to perceive themselves as different from others and outside the mainstream of ordinary life. This perception of being different may be shared by others, who may then reject them, their disability, and their differences. Part of this sense of being different can stem from the ongoing demands of the illness. For example, social relationships are interrupted because families and friends cannot adjust the erratic treatment to acceptable social activities. From such real events, or from social perceptions, social isolation can occur, either as a process or as an outcome.

Individuals with chronic illness often face their own mortality more explicitly than do others. Even if death does not frighten those with chronic illness, it frequently frightens those in their social networks, which leads to guilt, and can lead to strained silences and withdrawal. For those who lack this social support, social isolation is not merely a metaphor for death but can hasten it.

### Possible Causes

The list to the possible causes of social isolation is endless. Retirement, death of a spouse or significant other, health problems and even reduced income can create situations where one becomes separated from social contacts. The key, however, is how the elderly person and caregivers choose to respond to these changes because the responses can make the difference in creating a positive or negative result.

Social isolation can develop when living at home causes a lack of communication with others. This results in the elderly person feeling lonely due to the loss of contact or companionship, as well as a deficit of close and genuine communication with others. It also can be the self-perception of being alone even when one is in the company of other people. We discuss the impact of these few:

**A. Stigma:** Social isolation may occur as one effect of stigma. Many persons will risk anonymity rather than expose themselves to a judgmental audience. Because chronic illnesses can be stigmatizing, the concern about the possibility of revealing a discredited or discreditable self can slow or paralyze social interaction. In a study examining chronic sorrow in HIV-positive patients, stigma created social isolation. Therefore, social roles and the robustness of network support affect social isolation. The individual with chronic illness or their families grapple with how much information about the diagnosis they should share, with whom, and when. If the illness is manageable or reasonably invisible, its presence may be hidden from all but a select few,

often for years. Parents of children with chronic illnesses often manage stressful encounters and uncertainty by disguising, withholding, or limiting information to other, an action that may add to limiting their social network.

For example as siblings of children with infectious disease deal with the isolation of their brother or sister, they became vulnerable to being socially isolated themselves. Social isolation not only burdens those with chronic illness, it also extends into family dynamics and requires the healthcare professional to consider how the family manages. Nurses must explicitly plan for the isolation in families with children who are chronically ill. Thus, with social isolation being a burden for the family, it requires the healthcare professional to consider how. The family manages the illness and the isolation. Where the stigmatized disability is quite obvious, as in the visibility of burn scars or the odor of colitis, the person who is chronically ill might venture only within small circles of understanding individuals. Where employment is possible, it will often be work that does not require many social interactions, such as night work or jobs within protected environments (sheltered workshops, home offices). Regardless of what serves as reminders of the disability, the disability is incorporated into the isolates sense of self; that is, it becomes part of his or her social and personal identity.

**B. Social Rules:** Any weakening or diminishment of relationships or social roles might produce social isolation for individuals or their significant others. Those who lose family, friends, and associated position and power are inclined to feelings of rejection, worthlessness, and loss of self-esteem. These feelings become magnified by the person's culture if that culture values community. An example of social isolation of both caregiver and care recipient occurred in a situation of a woman whose husband had Alzheimer's disease. The couple had been confined for more than 2 years in an apartment in a large city, from which her confused husband frequently wandered. Her comment, "I'm not like a wife and not like a single person either," reflected their dwindling social network and her loss of wifely privileges but not obligations. This ambiguity is common to many whose spouses are incapacitated. Moreover, after a spouse dies, the widow or widower often grieves as much for the loss of the role of a married person as for the loss of the spouse.

The loss of social roles can occur as a result of illness or disability, social changes throughout the life span (e.g., in school groups, with career moves, or in unaccepting communities), marital dissolution (through death or divorce), or secondary to ostracism incurred by membership in a "Wrong" group. The loss of social roles and the resultant isolation of the individual have been useful analytic devices in the examination of issues of the aged, the widowed, the physically impaired, or in psychopathology.

**C. Age:** Old age with its possible many losses of physical and psychological health, social roles, mobility, economic status and physical living arrangements, can contribute to decreasing

social networks and increasing isolation. This will become even more of an issue as the numbers of older adults are expected to increase arithmetically and proportionately in the next two decades. The prevalence of social isolation in older adults has been approximated now to be at 2-20% and even as high as 35% in assisted-living arrangements [4].

Social isolation has been linked with confusion, particularly in older adults with chronic illness. But when the socially isolated are also immobilized, the combination of isolation and immobilization can lead to greater impairments, such as perceptual and behavioral changes (e.g., confusion, noncompliance, or time distortions). Physical barriers (such as physical plant designs) or architectural features (such as heavy doors) also contribute to social isolation or home-boundedness. All of these limits contribute to social isolation in ways that motivation alone cannot easily overcome.

Social isolation has been shown to be a serious health risk for older adults, with studies indicating a relationship between all-cause mortality, coronary disease, and cognitive impairments. In a converse finding, older adults with extensive social networks were protected against dementia. And, as described earlier, although low social engagement may not be a form of social isolation per se, it is a psychological isolator and thus a risk factor in social isolation. For example, depressive symptoms in older adults were shown to be decreased by social integration. Isolated older adults were shown to have increased risk for coronary heart disease, and death related to congestive heart failure was predicted by social isolation. Similarly, post-stroke outcomes, for example, strokes, myocardial infarction, or death, were predicted by pre-stroke isolation.

The extent and nature of a, social network from local to community, and integrated to contained, as well as the positive; or negative nature of the social relationships in the social network, impact health as well as social isolation. In fact, the quality of the social relationship may have more impact than the number of ties, which suggests that a few solid relationships may be more beneficial than many ties of poor quality.

### Social Isolation and Well-being

Generally discussions on well-being both the best methods for achieving it and whether or not it is an appropriate goal of human activity, have been frequent throughout history. It is known that health status and personality are the most important predictors of well-being. In consideration of the relationship between health status and age, studies show that overall dysfunction comes along with the aging process. However, it can also be influenced by the quality of life especially of social isolation and loneliness. In order to understand better well-being in the elderly, We shall analyze the meaning of well-being, the relationship between well-being and elderly and well-being with other predictors in order to find out if they are mutually contradictory [4].

In the contemporary policy and practice, Well-being has become a high profile issue. Rather than talking just about 'improving health' we are more likely to read about 'improving health and wellbeing', and similarly, the notion of 'welfare' is now accompanied by 'well-being': as well as 'doing well', the aim should be to 'be well.' Well-being has been associated with 'happiness', with 'quality of life' or 'life satisfaction'. And sometimes it is talked about as 'subjective well-being' or 'mental well-being.' So the idea of well-being involves how we feel about ourselves and our lives, rather than how our lives might be assessed by others [4].

In relation to elderly people and others who use social care services, the importance of 'activity' or 'healthy lifestyles' are highlighted as factors that contribute to quality of life, well-being and remaining independent. This is also based on the idea of 'choice' - which we can benefit from choosing how we live our lives and what services or supports will help us do so.

Psychologically, well-being is considered as a vital dimension of the elderly person's quality of life. Psychological well-being is generated by two dimensions which are absence of depression and emotional loneliness; and presence of happiness, life satisfaction, feeling of security, and plans for the future. An individual will be high in psychological well-being to the degree in which positives affect or predominate over negatives. On the other hand, when negative effects are in a dominant position, the individual will be low in well-being. That is to say, to gain subjective well-being, pleasure usually predominates over pain in one's life experiences.

It not surprising therefore, that some elderly people have talked about the significance of all kinds of relationships to their well-being. These included relationships with families, friends, neighbors, service providers, and also for some at least, the nature of casual encounters with strangers at bus stops, at the checkout counter of supermarkets and elsewhere. People feel a sense of security knowing a neighbour is looking out for them, and the opportunity to have a chat and cup of tea can help if someone feels isolated. The opportunity to strike up conversations in public spaces can also help people who have limited social contact to feel connected, particularly if families are rarely seen and friends have died. Losing friends can also mean losing the chance to share memories and some people suggested that, not only is it hard to make new friends in old age, 'new friends' do not carry the history that 'old friends' do. So that when people join in activities in the hope that they may develop new connections, this may not always positively contribute to a sense of well-being.

Friendships are important at any age. The older people we interviewed talked about how friends contributed to well-being through offers of practical help, sustaining connections with their past, and also by enabling them to give back and contribute to the well-being of others. Family relationships can be a source

of support, security, joy and pleasure. They can also enable older people to contribute to others' well-being; not only caring for partners, grandchildren or other relatives, but offering their knowledge and experience (e.g. of places they have visited, journeys they have made) for the benefit of younger people starting out on exploring the world. Two way learning and support (e.g. grandchildren helping them use the internet) helps older people feel they are involved in reciprocal relationships, helps them feel valued, stay in touch with the world and maintain their sense of identity.

## Social support in isolation

Social support was initially defined by taking cognizance of the number of friends an individual has; but this definition has been extended to include the person's satisfaction with the support that is rendered. Social support could include esteem support, whereby a person's self-esteem is boosted by other people, informational support that includes information provided by other people, and social companionship, which consists of support rendered by means of activities. Finally, instrument support involves a form of physical assistance. Social support has also been defined by some authors as any input that can further the goals of the receiver. Social support can be tangible, including provision of physical resources that can be beneficial to the individual in some way, or psychological, that assists the individual in developing emotional well-being. Social support can also be explained as the specific people or community resources to which an individual turns for emotional and instrumental assistance. While social support could be defined as the active participation of significant others in the caregiver's efforts to manage stress, caregivers can easily become isolated from social support as a result of their confinement and responsibilities, which places them increasingly at risk for stress-related illnesses. Both the caregiver's as well as the patient's quality of life can be adversely affected, as social support is important for coping and satisfies the need for attachment, a feeling of self-worth, stress relief, and so on. However, social support is generally defined as any action that is to the advantage of the receiver of such support.

## Categories of Social Support

There are six criteria of social support that researchers have used to measure the level of overall social support available for the specific person or situation [2]. First, they would look at the amount of attachment provided from a lover or spouse. Second, measuring the level of social integration that the individuals involved with, it usually comes from a group of people or friends. Third, the assurance of worth from others such as positive reinforcement that could inspire and boost the self-esteem. The fourth criterion is the reliable alliance support that provided from others, which means that the individual knows they can depend on receiving support from family members whenever it was needed. Fifth, the guidance of assurances of support given to the individual from a higher figure of person such as a teacher

or parent, the last criterion is the opportunity for nurturance. It means the person would get some social enhancement by having children of their own and providing a nurturing experience.

Two other major categories of social support have also been identified [4], tangible support, which may include physical resources that could be beneficial to the receiver; and psychological support, which assists the receiver in developing beneficial affective or emotional states. Psychological support helps a person to feel more content (or to feel better). It is clear that social support from family and friends have an important role to play in assisting a person to translate intentions into health behaviours, while the absence of social support can have a detrimental effect on the individual's overall health. Social support can also consist of support from individuals such as friends, family members, neighbors, co-workers, professionals and acquaintances. All types of support have been found to be beneficial in helping individuals to cope during a serious illness. There is enough evidence to suggest that in general people who receive support enjoy better health than those who do not receive such support.

## Therapeutic effects of social support

Social support is one of most important factors in predicting the physical health and general well-being of everyone, ranging from children through older adults. The absence of social support shows some disadvantages among the impacted individuals. In most cases, it can predict the deterioration of physical and mental health among the victims. A regular social support is a determining factor in successfully overcoming life stress. It significantly predicts the individual's ability to cope with stress. Knowing that they are valued by others is an important psychological factor in helping them to forget the negative aspects of their lives, and thinking more positively about their environment. It not only helps improve elderly person's well-being, it affects the immune system as well. Thus, it becomes a major factor in preventing negative symptoms such as depression and anxiety from developing. Social support and physical health are two very important factors that help the overall well-being of an elderly person. A general theory that has been drawn from many researches over the past few decades postulate that social support essentially predicts the outcome of physical and mental health for everyone.

Studies have equally shown that social support can effectively reduce psychological distress during stressful circumstances. In addition to providing psychosocial benefits, it appears to reduce the likelihood of illness and to speed up recovery from illness. It is clear therefore that social support helps individuals to obtain a more positive outlook on life, increases self-esteem and resistance to illnesses, and encourages people to engage in more positive, health-promoting behaviours. The form of it received can play an important role. For example, if someone needs emotional support and receives only tangible support, it can further add to the person's frustration and stress. Studies

have shown that immuno-suppression may be reduced by social support, which confirms the notion that social support promotes health in general [6]. It also indicates that people with a high quantity and sometimes a high quality of social relationships have lower mortality rates. Social support appears to help people to effectively resist illnesses and minimize complications from serious medical conditions.

Its regular provision essentially predicts the outcome of elderly adults' general health condition. Inadequate social support at any time would predict that elderly adults will develop depressive symptoms over time. Elderly adults would be able to ignore the negative effects in their lives with help and reinforcement from others. This is considered a psychological effect. A lack in the availability of social support would likely make the individuals notice their daily hassles and life stressors much more clearly. This step could accelerate the deteriorating effect of their physical and mental health [7].

## Conclusion

There is evidence that social experience is very essential in predicting successful aging and well-being for everyone, ranging from childhood through older adults [8]. After a few decades of studies, researchers have finally gained some understanding about the relationship between social support, successful aging and well-being. Nonetheless, some areas of research still face some problems because they sometimes focus on one population, ignoring the generalization rules for using the random samples to generalize the result to a whole population [4].

The continuity of research on the effects of social isolation and the relationship between social support and general well-being of elderly population will enable us to understand better the effects of good social support toward physical and mental health, along with a general well-being. Many studies have

shown that if a high level of social support becomes available to the elderly population, it will benefit their overall health in a long run. The importance of social support implies to everyone in our society, ranging from young childhood through older adulthood. The providers of social support can be anyone in society who brings positive environment and reinforcement to the individuals, especially from their family members. This article is optimistic that we can have a dramatic impact on the success or failure in aging, and that there is the possibility of continued growth and development in the later years. Not only physical well-being will be improved, but also emotional and spiritual well-being, when retirement and 'aging in place' become the best stage of all instead of an indirect isolation.

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