CASCH
Canadian Alliance for Social Connection and Health

GENWELL PROJECT
HUMAN CONNECTION MOVEMENT

Evidence Brief

# What is social health?

## Background

Decades of scientific research highlight loneliness, social isolation, and poor quality relationships as major risk factors for poor physical and mental health (Kemp et al., 2017). These findings highlight the importance of understanding our social health and the mechanisms by which it impacts our overall wellbeing. However, social health remains a relatively new concept and people may wonder which aspects of our social lives are most important to our social health. Understanding these nuances can provide us a better understanding of what social health is and how it can be obtained.

## Purpose

The purpose of this evidence brief is to examine features of social health and their impact on individual health and wellness.

## Evidence from Existing Studies

### *Dimensions of "Social Health"*

For more than a century, scientific studies have examined the health impacts of social disconnection, beginning, perhaps, with the first empirical work of modern sociology by Emile Durkheim, which examined the social causes of suicide (Durkheim, 1897). Yet, despite decades of research on this topic, there is no universally accepted definition for "social health" (Vernooij-Dassen et al., 2022; Soofizad et al., 2022) Most references to the concept date back to the writing of the World Health Organization's Constitution which defined health "as a state of complete physical, mental, and social wellbeing" (Sartorius, 2006). Despite the lack of a consensus definition expanding on this statement, it is generally understood that social health represents the dimension of wellbeing associated with one's social interactions and relationships (Donald et al., 1978; Cassel, 1976). However, rather than simply describing the absence of social ailments (e.g., *loneliness, social anxiety, interpersonal conflict, social isolation*), social health is characterized by the quantity and quality of diverse social relationships and interactions that provide a sense of inclusion, belonging, and connection to others at the interpersonal, communal, societal, and planetary levels, as well as one's capacity for optimal social functioning within these varied social environments (Doyl & Link, 2022; Delgado et al., 2023; Huan & Peterson, 2022). Another way of understanding social health is in terms of needs fulfillment. For example, Erskine et al. (1999) describes eight relational needs which outline key ways we are fulfilled by our social relationships. These include (1) the need to be safe and secure; (2) the need to feel valid, affirmed, and significant; (3) the need to be accepted, (4) the need to have one's experiences confirmed, (5) the need to develop a sense of self-definition through one's social life, (6) the need to have impact and influence over others, (7) the need to be engaged by others, and (8) the need to express one's love (Žvelc et al. 2020).

Given this broad scope, countless terms and concepts have been introduced into the research literature to describe dimensions of social health (Teshale et al., 2023; Hodgson et al., 2020; Wang et al., 2017; Kawachi, 1999; Ryff & Keyes, 1995). Among these are loneliness, social isolation, social support, existential isolation, belonging, social status, social cohesion, peer influence, social capital, social trust, social skills, community connectedness, collectivism-individualism, social exclusion, social anxiety, social functioning and so on (Simo et al., 2023; Justwan et al., 2018; Wong et al., 2016; Prinstein et al., 2011; Jensen, 2010; Putnam, 2010; Heitzmann & Kaplan, 1988; Hui et al., 1988; Smith, 1975). The various concepts related to social health have been conceptualized using a variety of frameworks. For example, some bodies of literature focus on assets (e.g., neighbourhood cohesion) while others focus on deficits (e.g., social isolation, loneliness; Morgan & Ziglio, 2007; Huang & Peterson, 2022). Some studies emphasize distinctions between subjective qualitative dimensions (e.g., *loneliness, belonging, perceived social support*) and others focus on objective quantitative dimensions (e.g., *social network size, time spent socializing;* Fiordelli et al., 2020). Furthermore, social health has been described at the individual level (e.g., *social skills, sense of belonging*), interpersonal level (e.g., *social support, peer influence*), and on the community or group-level (e.g., social cohesion, collectivism-individualism; Venzon et al., 2019; Zare et al., 2019; Holt-Lunstad, 2018). Additionally, researchers have explored intersections across a large number of social processes (e.g., bonding, friendship-making; Prior et al., 2022; Pezirkianidis et al., 2023), social characteristics (e.g., status, extraversion, skill-level; Segrin, 2019; Stringhini et al., 2017), and diverse types of social connections (e.g., acquaintanceships, friendships, intimate relationships; Sprecher, 2022).

### *Key Social Health Dimensions*

In short, the social health literature is expansive and complex – encompassing many tens of even hundreds of thousands of studies. To manage this complexity, the remainder of this brief focuses on a few key concepts that we have observed to be robustly studied in relation to physical and mental health. In selecting components, we have attempted to identify those which are conceptually distinct, while deprioritizing those that are synonymous or have a high degree of conceptual overlap.

**Social isolation** refers to the objective state of having minimal contact or sustained interaction with others, whether by circumstance or by choice (Holt-Lunstad & Steptoe, 2021; House et al., 2001). Social isolation is objectively quantifiable and can be assessed by measuring the frequency and type of social engagements a person has, their social network size, or other measures describing their interactions and connections with others (Almeida et al., 2021; Freak-Poli et al., 2021; Loades et al., 2020; Cacioppo et al., 2010; Gini & Espelage, 2014; Lubben et al., 2006; Zadro et al., 2004; Berkman & Syme, 1979). Research suggests that social isolation affects health, contributes to social anxiety, social vigilance, and other aversive and debilitating conditions (Donovan et al., 2020; Hawkley & Cacioppo, 2010). Conversely, social interaction involves connection with others and has been consistently found to be beneficial to health and wellbeing (Hall & Morella, 2020; Zhang et al., 2019; Helliwell & Wang, 2011). Various researchers have explored the effects of having larger social networks and more frequent interactions – finding that greater social contact has positive health and social effects (Hall et al., 2023; Zhang et al., 2019).

**Loneliness** is the subjective feeling of a deficit in social connections or the emotional experience of perceived isolation (Beutel et al., 2017; Cacioppo & Patrick, 2008; Perlman & Peplau, 1981; Russell et al., 1980; Hartog et al., 1980; Weiss, 1973) with direct and indirect negative health effects (Cacioppo & Cacioppo, 2014; Gomboc et al., 2021). It is a complex emotional state that does not necessarily correlate with the number of social interactions a person has but rather the quality and meaningfulness of those interactions (Fiordeli et al., 2020). Many studies distinguish between emotional and social loneliness (Russell et al., 1984). Emotional loneliness represents the lack of satisfactory, fulfilling emotional attachments, while social loneliness represents the lack of contact and interaction with others (Weiss 1974, 1989; de Jong Gierveld & van Tillburg, 2008). Additionally, emotional loneliness can further be broken down into romantic and family subtypes (DiTommaso & Spinner, 1997; McClelland et al., 2022). Researchers have also discussed the importance of existential loneliness (Larsson et al., 2019), which is conceptualized as a sense of interpersonal alienation or lack of belonging (Pinel, 2021). This form of loneliness differs from emotional and social loneliness in that it represents an underlying feeling of separateness from others that is not remedied by the presence or development of relationships with others. In other words, it reflects a fundamental sense of disconnect with not only specific individuals, but from others more generally; a sense of unresolvable isolation and lack of shared experience with others (vanTilburg et al., 2020).

**Social anxiety**, also known as social phobia, is a mental health condition characterized by an intense, persistent fear of social situations (Baker et al., 2002; Westenberg, 1998; Nutt et al., 1998). Individuals with social anxiety often fear negative evaluation, embarrassment, or humiliation in social interactions, which can lead to significant distress and avoidance behavior (Marks & Gelder, 1965). Social anxiety is related to, but clinically distinct from shyness and other social attributes. It is a risk factor for loneliness and isolation (Solano et al., 1989).

**Social support** is the provision of emotional, instrumental, or informational assistance by a social network, which includes family, friends, and other social ties (Gottlieb & Bergen, 2010; Cutrona & Suhr 1992; Berkman, 1985). This support can serve as a buffer against stressors and can contribute to both psychological and physical well-being. According to Gable & Bedrov (2022), people who lack social support "suffer more when bad things happen and gain less when good things happen." This is because social support serves as a buffer against aversive experiences and enhances the effects of positive experiences (Cohen & Willis, 1985). Often, social support is measured by assessing both the quantity of social contacts one has and the quality of those contacts – with specific attention to the ways relationships provide support.

**Relationship quality.** The quality of social contacts is also an important determinant of health (Hall & Morella, 2020; Lyubomirsky et al., 2011). High quality relationships are those which meet individual's diverse needs for rewarding, meaningful, and supportive connection with others. They provide a sense of relatedness and belonging (Haim-Litevsky et al., 2023; Kluwer et al., 2020). High quality relationships are deeper, more secure, more trusting, and more vulnerable with a stronger sense of commitment and interdependence (Pezirkianidis et al., 2023; Joel et al., 2020; Wong & Sohal, 2002).

**Social status** is the hierarchical position or rank that an individual holds within a social structure, often determined by factors such as occupation, wealth, education, and social connections (Marmot, 2005; Karvonen & Rahkonen, 2011). This status can influence the access to resources and opportunities, thereby affecting health outcomes. Furthermore, low

social status can negatively influence psychological wellbeing and stress responses and shape health behaviours (Matthews & Gallo, 2011; Wang & Geng, 2019; Navarro-Carrillo et al., 2020).

**Social skills** are the competencies used to understand, interact and communicate effectively with others. These skills enable individuals to understand social cues, engage in conversation, resolve conflicts, and form meaningful relationships (Riggio, 1986; Rose-Krasnor, 1997). Adequate social skills are essential for emotional well-being and functional social interaction and lack of social skill has been linked with a wide variety of poor health and social outcomes (Jones et al., 1982; Jones et al., 2015; Lodder et al., 2016; Kurimoto et al., 2020). Notably, Segrin (2007; 2017) notes that poor social skills are related to poor health outcomes due to increased levels of loneliness and stress.

**Social capital and social cohesion** are closely related but distinct concepts that are important to health (Kawachi & Berkman, 2014; Chuang et al., 2013). While social cohesion focuses on shared values, norms, and a sense of belonging within a community, social capital emphasizes the actual relationships and networks that enable members to work together effectively (Forrest & Kearns, 2001). High levels of social capital can contribute to social cohesion by promoting trust, cooperation, and collective action, which in turn can reinforce social capital (Kawachi & Berkman, 2014). Communities with high levels of social capital and cohesion have been shown to be optimized for producing health and wellbeing.

**Peer influence** is the impact that individuals within a social network have on each other's behaviors, attitudes, or opinions. This influence can be either positive or negative and is particularly potent during formative years but remains significant throughout the life course (Giletta et al., 2021; Christakis & Fowler, 2013; Tome et al., 2012; Prinstein et al., 2001). Peer influences are widely believed to impact health and wellbeing by their influence on behaviours and choices (Ciranka & van den Bos, 2019).

### *Relative contributions of Social Health Dimensions to Physical and Mental Wellbeing*

Given the scope of concepts related to social health, it is unsurprising that few studies have isolated the effects of these various social dimensions on human health. One reason for this is that various measures of social health are often correlated with one another and as such only a subset of social health measures have typically been included in any given study (Hajek et al., 2020; Wang et al., 2017). However, a growing number of studies have begun to compare the various aspects of social health. These studies have primarily focused on contrasting measures of social isolation and connection with those of loneliness. Moreover, within the context of loneliness, researchers have compared its social and emotional forms of loneliness and the differential effects of relationship quality versus quantity.

***Social Isolation and Loneliness.*** In studies comparing isolation and loneliness, the results have been mixed. Some studies have found that social isolation is a more important risk factor for morbidity and mortality (Wang et al., 2023; van der Velpen et al., 2022; Freak-Poli et al., 2021; Holwerda et al., 2012; Yu et al., 2020; Hakulinen et al., 2019; Penninkilampi et al., 2018; Tanskanen & Anttila, 2016; Steptoe et al., 2013). For example, a recent high-quality meta-analysis of longitudinal cohort studies by Wang et al. (2023) reported that the effect of social isolation (1.32 [1.26, 1.39]) on all-cause mortality was approximately twice that of the effect of loneliness (1.14[1.08,1.20]). However, other studies have reported that loneliness is a more important risk factor (Pressman et al., 2005; Holwerda et al., 2012), and some find that the



two factors work independently and/or synergistically to produce poor health (Schutter et al., 2022; Ward et al., 2021; Beller & Wagner, 2018; Kraav et al., 2020; Holt-Lunstad et al., 2015; Shankar et al., 2011). Providing some clarity, Hong et al., (2023) reports that social isolation is more strongly related to physical health outcomes and loneliness is more strongly related to psychological outcomes – highlighting the likely complexity of pathways and mechanisms at play.

***Emotional and Social Loneliness.*** Likewise, studies comparing emotional and social dimensions of loneliness have also been mixed with some showing a stronger effect of emotional loneliness on health-related outcomes (Peerenboom et al., 2015; Gomboc et al., 2022; O'Suilleabhain et al., 2019; Dahlberg & McKee et al., 2014; Drageset et al., 2012) and others showing a stronger effect for social loneliness (Brandts et al., 2021; Hayslip et al., 2022). Moreover, recent research suggests that these types of loneliness are differentially important for different outcomes (Hofman et al., 2022; Hopp et al., 2022). In examining the nature and effects of emotional and social loneliness, research suggests that emotional loneliness is more strongly related to emotional disruptions and mental health symptoms such as depression and anxiety, while social loneliness is more strongly linked to objective social conditions, such as isolation, network size, and neighbourhood factors (Wolters et al., 2023; Wolfers et al., 2021; Hofman et al., 2022; Stephens & Phillips, 2022; Dahlberg & McKee et al., 2014). These different pathways may explain the nuances in the relationship between each dimension of social health. For example, emotional loneliness may impact health through pathways related to emotions and stress while social loneliness may impact health through pathways related to positive peer pressure, social capital, instrumental support, and other social network-based drivers of health. In any case, it is unclear from the existing literature which dimensions of social health are most important to physical and mental health.

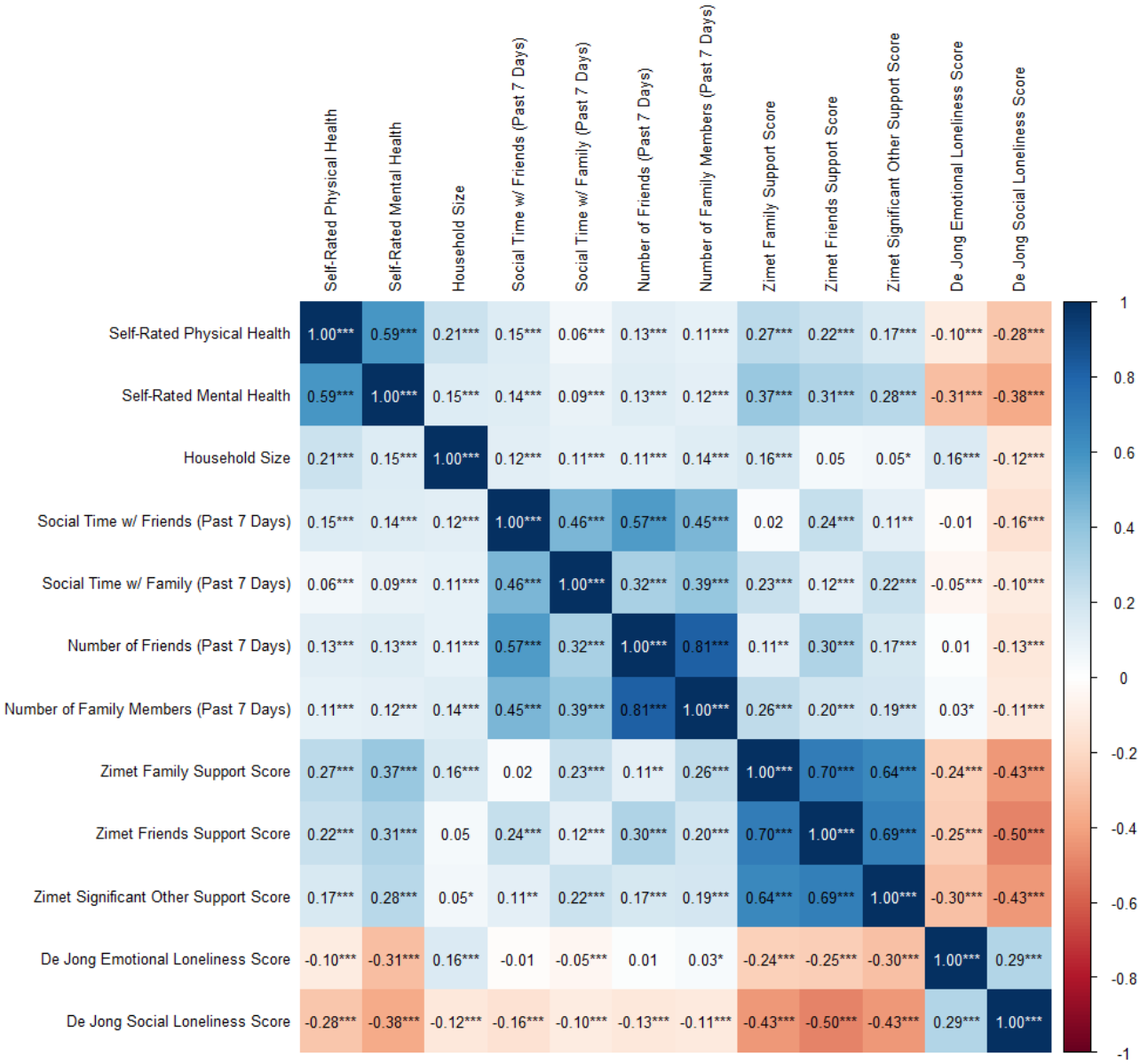
**Quality versus Quantity**. A third comparison that has been frequently explored is the relationship between relationship quality and quantity of social interactions. These studies generally suggest that the quality of social contacts and the depth of communication have a greater connection with well-being than the frequency of engagement (Shang et al., 2022; Mueller et al, 2022; Bena-Bachman et al., 2020; Zhaoyang et al., 2019; Bernstein et al., 2018; Cantisano et al., 2015; Fiorillo & Sabatini, 2011; Mehl et al., 2010). However, a few studies do support the importance of quantity, over quality for some health and social outcomes (Barger et al., 2013; Pollack et al., 2016). Clearly both are important, especially given that quality engagements are conditional on access to others (Williamson & Schouweiler, 2023; Sun et al., 2020; Hall, 2020; Dias et al., 2018; Xing et al., 2017; Smith et al., 2012; Cornwell & Waite, 2009; Appleyard et al., 2007). That said, given that our social lives are limited by the amount of time we have to socialize, it is important to acknowledge that there are natural trade-offs in how many social contacts we have and our depth of connection with them (Zhong et al., 2019).

## Analyses from The Canadian Social Connection Survey

Using data from the Canadian Social Connection Survey, we examined the intercorrelations between multiple social health dimensions, including Self-Rated Physical Health, Self-Rated Mental Health, Household Size, Social Time with Friends in the Past 7 Days, Social Time with Family in the Past 7 Days, Number of Friends Interacted with in the Past 7 Days, Number of Family Members Interacted with in the Past 7 Days, Zimet Multidimensional Social Support Family Subscale Score, Zimet Multidimensional Social Support Friends Subscale Score, Zimet



Multidimensional Social Support Significant Other Subscale Score, De Jong Emotional Loneliness Subscale Score, and De Jong Social Loneliness Subscale Score.




In multivariable models (n = 1,343) adjusting for age, gender, ethnicity, and income, self-rated physical health ($R^2$ = 0.190) was positively associated with larger household size (B = 0.024, p = 0.005) and greater social support from family (B = 0.156, p < 0.001), and negatively associated with not spending time with any friends in the past seven data (B = -0.309, p = 0.005), higher emotional loneliness (B = -0.085, p = 0.008), and higher social loneliness (B = -0.065, p = 0.024). Similarly, self-rated mental health ($R^2$ = 0.323) was positively associated with larger household size (B = 0.041, p < 0.001) and greater social support from family (B = 0.200, p < 0.001), and negatively associated with not spending time with any friends in the past seven data (B = -0.306, p = 0.006), higher emotional loneliness (B = -0.299, p < 0.001), and higher social loneliness (B = -0.096, p = 0.001).

Notably, these results highlight several important patterns. First, the subjective components (e.g., perceived social support, loneliness) were highly important – underscoring the importance of having high quality and fulfilling relationships. Nevertheless, independent effects were observed for reporting a higher number of social interactions (e.g., number of friends visited in past seven days). Second, social support form family was an important predictor of both mental and physical health, while support from friends and significant others were not independent predictors. Third, the effect of emotional loneliness was considerably larger in predicting mental health compared to physical health; while the effect size of social loneliness was similar across the two outcomes. Fourth, in comparing emotional and social loneliness, the effect of emotional loneliness on self-rated health was generally stronger than the effect of social loneliness, particularly so in the case of mental health (with similar effect sizes between the two variables observed for physical health. Finally, the variables included in these models explained nearly twice the variation in mental health than they did physical health.

## Discussion

Based on the evidence summarized above, it is clear that social health is a complex, multifaceted construct that manifests across various dimensions. These dimensions are often studied in isolation, yet they are interconnected and work together to shape our mental and physical well-being. To date, few studies have sought to integrate the various measures of social health in order to assess their relative and synergistic effects on health. Those that do highlight the importance of both getting enough social connection, but also ensuring that the social connections one has are of high quality. Future studies should aim for a more integrated approach, incorporating multiple dimensions of social health to understand their collective and individual impacts better. Such approaches can improve our understanding of social health and help with the design of interventions that can appropriately target key pathways between social wellbeing and mental and physical health. Given the current state of the literature, it is difficult to say which dimensions of social health are most important and their relationship to one another remains poorly understood. Furthermore, continued conceptual development of "social health" as a core pillar of human and planetary wellness is needed.

## Conclusion

While additional research is needed to understand social health and the mechanisms by which is shapes human health, it is clear that efforts are needed to address social health deficits such as loneliness, isolation, and social anxiety while also promoting social health assets such as social support, capital, and cohesion. This is underscored by the considerable effect that social health dimensions have on human health. Recognizing these, we recommend that policy and decision makers, healthcare providers, and other community leaders include social health as a key priority for policy and practice and make appropriate investments to identify and implement optimal social health promotion strategies.

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