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GENWELL PROJECT
HUMAN CONNECTION MOVEMENT

Evidence Brief

What drives social health inequalities?

Background

Loneliness is routinely defined as the unpleasant feeling that arises from the perception that one's social life is somehow deficient or inadequate (Perlman & Peplau, 1989). Consistent with this definition, researchers have proposed that this unpleasant feeling arises from a subset of neural processes which (a) monitor our social status, (b) compare our level of social connectedness to an ideal, person-specific target level (i.e., a homeostatic set-point) of connection, and (c) when discrepancies between observed and targeted social connections occur, these neural processes engage to regulate cognition in behaviour in ways that motivate individuals to achieve the targeted level of social connection (Matthews & Tye, 2019). In this way, loneliness has been compared to hunger and thirst and described as a fundamental motivational asset. However, when individuals are unable to achieve their homeostatic set-point, these neural and biological processes become disrupted – leading to harmful levels of chronic stress, passive coping, and maladaptive stress (Lee et al., 2021). As such, it is critical to understand the social processes and factors that inhibit individuals from meeting target-levels of social interaction, thereby contributing to social health inequalities.

Purpose

The purpose of this evidence brief is to explore the sources of and mechanisms contributing to social health inequality. In doing so, we are primarily interested in fundamental mechanism and processes. As such, while we acknowledge that the unequal distribution of specific situational risk factors may contribute to inequalities in social health, this review focuses on the upstream factors that contribute to the unequal distribution of these risk factors in the first place.

Evidence from Existing Studies

In contemporary society, there are undoubtedly many factors that shape one's ability to meet their social health needs. For example, physical or mental impairments may make it difficult for individuals to access and participate in social activities (Gooding et al., 2017). Similarly, unemployment, relocation, divorce, and death all can create situations that greatly disrupt our social life (Freak-Poli et al., 2022; Morrish & Medina-Lara, 2021; Hognas, 2020; National Academies of Sciences, 2020). However, while such situational and life course factors are salient for those affected, most people experience an abundance of social opportunity (Candiotto, 2022; Hammoud et al., 2021) – particularly since the advent of the internet and other communication technologies which have given us unprecedented ability to connect. Furthermore, empirical studies find that while changes in how much a person socializes does influence their experiences of loneliness, most variation in loneliness at the population-level occurs between individuals (Awad et al., 2023). This means that loneliness is fairly stable within individuals (Mund et al., 2020) and that some people appear to be consistently lonelier than others (Vanhalt et al., 2013). Supporting this, objective measures of social isolation and

interaction have been shown to be only weakly predictive of levels of loneliness reported between individuals (Danverts et al., 2023; Lennartsson et al., 2022; Cornwall & Waite, 2009). As such, rather than focusing exclusively on social behaviour and social opportunity, it is necessary to identify the social processes that inhibit social interaction and inclusion and thereby give rise to persistent inequalities in social health.

Indicators of poor social health are heterogeneously distributed across the population (Cohen-Mansfield et al., 2016; Page & Cole, 1991) with disproportionate impacts born by older adults (Shiovitz-Ezra et al., 2018), low-income individuals (Halpern-Meekin, 2019; Devicienti & Poggi, 2010; Pinquart & Sorensen, 2010; Stewart et al., 2009; Dahl et al., 2008; Hawkley et al., 2008, people with disabilities or chronic illness (Burholt et al., 2017; Bosma et al., 2015), people with mental illness (Yildirim & Budak, 2019; Elmoudden, 2019; Switaj et al., 2015; Livingston & Boyd, 2010), people who use drugs (Muncan et al., 2020) 2SLGBTQ+ people (Chan et al., 2022; Gorczynski & Fasoli, 2021; Bowling et al., 2020; Hughto et al., 2015), unhoused people (Reilly et al., 2022); people with excess body weight or other "physically unattractive" characteristics (Alimoradi et al., 2020; Anderson et al., 2001; Zakahi & Duran, 1988; Goldman & Lewis, 1977), and racial or ethnic minorities (Benner et al., 2018; Victor et al., 2012).

Underlying these inequalities are experiences of stigma, rejection, exclusion, and marginalization, which contribute to the development, trajectory, and maintenance of poor social health (Meisters et al., 2021; Foulk et al., 2019; Mulvey et al., 2017; Pavri, 2015; Rokach, 2014; Vanhalst et al., 2013; Frost, 2011; Woodhouse et al., 2011; Baumeister et al., 2007; Wilkinson, 1999; Asher & Wheeler, 1985). For example, while a variety of mechanisms are likely in play, individuals who experience discrimination or social exclusion may withdrawal, which while employed as coping strategy can also contribute to isolation and distress (Elsayed, 2022; Eck et al., 2016; Nielsen & Knardahl, 2014; Rubin et al., 2009; Kalisch et al., 2005; Evans et al., 2000; Vallejo, 1986). Importantly, these ill effects occurring at the individual appear to cascade through social networks neighbourhoods (Cacioppo et al., 2009) – with higher rates of loneliness in resource poor neighborhoods and peripheral regions of social networks (Menec et al., 2019; Kearns et al., 2015).

On the other hand, those with higher social power, prestige, and capital have fundamentally different social experiences compared to those who are marginalized, rejected, disempowered, or oppressed (Cai et al., 2021; Jiang et al., 2020; Nyqvist et al., 2016; Simpson et al., 2015; Waytz et al., 2015; Cheng et al., 2013; Cacioppo et al., 2010; Gallois, 1994). In particular, there is compelling evidence that wealthier and higher status individuals experience better social health outcomes (Niedzwiedz et al., 2016; Mullins, 1996). These experiences arise from, in part, a more positive sense of their social status, sense of self-worth, and self-efficacy (Vanhalst, 2015; Zhang et al., 2015; Narayanan et al., 2013; Vitkus & Horowitz, 1987; Jones et al., 1983). As well, they receive more positive social feedback and may benefit more from their social engagements (Reis, 1982). Of course, these social inequalities can also create harms for those at the top by creating a sense of isolation from others and allowing socially impermissible abuses of social power (Magee, 2019; Zumaeta, 2018; Smith & Magee, 2015; Lindorff, 2010; Lee & Tiedens, 2001).

In understanding the disproportionate burden faced within marginalized communities, it is important to clarify the particular mechanisms and causes. In particular, we note that the burden of poor social health on marginalized communities is unlikely to arise from genetic or biological

factors alone (Spithoven et al., 2019; Baker, 2007), even though loneliness has been observed to have a strong genetic component (Abdellaoui et al., 2019; Day et al., 2018; Spithoven et al., 2019; Gao et al., 2016; Goossens et al., 2015). Instead, it is important to note that the harms afflicting these identities arise from modifiable social conditions, such as experiences of stigma and discrimination (Visser & Fakiri, 2016). As well, studies which fail to show an association between loneliness and social marginalization should not necessarily be interpreted as providing evidence for the lack of social health inequalities. This is because resilience within minority communities can help communities cope with and even flourish in the face of adversity (Haslam et al., 2021; Meyer, 2015; Hawkley et al., 2008). For example, communities with a strong sense of identify may form strong intra-group ties which can help individuals develop close, fulfilling relationships even when stigmatized by mainstream society. Such efforts can lead to lower levels of loneliness within these communities, but this does not undermine the reality that they face social marginalization in the first place.

In focus: Understanding the Stigma Associated with Loneliness

In addition to the stigmas associated with low social status, loneliness is also stigmatized (Barreto et al., 2022; Kerr & Stanley, 2021; Rotenberg & MacKie, 1999; Rotenberg, 1989; Lau & Gruen, 1992). Indeed, people may view loneliness as the fault of lonely individuals – attributing it to poor social skills, low motivation, or other unfavorable characterizations (Fiske et al., 2016). These negative perceptions may lead to discrimination and exclusion, just as other forms of stigma do (Weiner, 1988). Further, lonely individuals may be labeled as loners or may be assumed to be disinterested in social interaction. These negative stereotypes reinforce the social challenges experienced by lonely people, who already experience heightened social vigilance and fear of rejection (Sjastad et al., 2019; Watson & Nesdale, 2012). In this way, the social stigma of loneliness may reinforce experiences of loneliness – highlighting the need to de-stigmatize loneliness.

The stigma of loneliness is somewhat counter-intuitive, given that researchers have argued that loneliness and other mood disorders serve as evolved social signals designed to signal need for help and that one is not a threat (Allen & Badcock, 2003). Supporting this view, researchers have found that loneliness can be identified through social signals (Guntuku et al., 2019; Luhmann et al., 2016; Tsai & Reis, 2009). However, regardless if the stigma of loneliness is an adaptive response, it is clear that if we are to address loneliness, we must rethink its meaning and significance in our lives and the lives of others. Like other sources of stigma, we must recognize that the problem is not within individuals, but is instead a byproduct of the broader social environments in which they have developed and exist.

As such, regardless of whether such resilience is sufficient to overcome the harmful effects of stigma, interventions are necessary and fortunately, effective interventions for social stigma are emerging (Ham & Yang, 2020; Rao et al., 2019). Among the most effective approaches are those which facilitate direct social contact across groups, support social cohesion within groups, and correct misperceptions or negative biases (including internalized biases; Chan et al., 2022; Hsieh et al., 2021; Dunbar et al., 2020; Argento et al., 2016; Lemmer & Wagner, 2015; Beelmann & Heinemann, 2014; Livingston et al., 2012; Thornicroft et al., 2008). Of course, such interventions require tailoring to ensure they help participants overcome barriers to participating in them (Mmako et al., 2018). That said, by reducing stigma and increasing social

capital, reductions in loneliness and other poor indicators of social health can be achieved (Coll-Planas, 2017). As well, among individuals who face social stigma and loneliness, it may be beneficial to help them develop acceptance, mindfulness, and cognitive reframing skills, which can help them manage the challenging social environments in which they live, overcome internalized stigma, and develop positive experiences with being alone (Zarling et al., 2023; Mahmoudpour et al., 2021; Khoramnia et al., 2020; Rodriguez et al., 2020; Lindsay et al., 2019).

Analyses from The Canadian Alliance for Social Connection and Health

Using data from the Canadian Social Connection Survey, we created a social marginalization index, which classified individuals by the number of typically marginalized characteristics they reported. Marginalized characteristics included non-white ethnicity, 2SLGBTQ+ identity, mental or physical impairment, age over 65, and household income below $30,000 CAD. Analyses of these data revealed that higher social marginalization index values were associated with significantly greater experiences of everyday discrimination ($\beta = 0.104$, SE = 0.002, $p < 0.001$), higher UCLA loneliness scores ($\beta = 0.029$, SE = 0.0113, $p = 0.010$), lower odds of reporting at least 5 close friends (vs. 0; $\beta = -0.430$, SE = 0.098, $p < 0.001$), lesser family social support ($\beta = -0.079$, SE = 0.016, $p < 0.001$), lesser friend social support ($\beta = -0.063$, SE = 0.017, $p < 0.001$), and lesser significant other social support ($\beta = -0.074$, SE = 0.015, $p < 0.001$).

Discussion

Social marginalization and exclusion are important determinants of social health – contributing to a wide range of adverse social health outcomes. While ongoing research is needed to understand these effects and how to best intervene to mitigate inequalities, it is clear that reducing social health inequalities requires the promotion of equity, diversity, and inclusion – with focus on eliminating stigma, discrimination, and violence and building social cohesion within and between identity groups.

Conclusion

Based on the evidence reviewed above, we recommend investments across all levels of society to reduce stigma and prejudice and promote equity, diversity, and inclusion.

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