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| **COLOR CODE** | **RANKING CODE** |
| DA LEGGERE, INTERESSANTE | 0: very relevant (method+topic) |
| LETTO, UTILE | 1: relevant (method+topic) |
|  | 2: interesting (topic) |
|  | 3: kinda interesting (topic) |
|  | 4: just literature review |
|  | 5: not interesting |

|  | **Reading** | **Main Argument** | **Notes** | **Comments** |
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| 2 | Lebenbaum, Laporte, Oliveira (2021) - *The effect of mental health on social capital: An instrumental variable analysis* | * What is the effect of MH on social capital? * Examine the impact of self-reported MH on weak tie social connections (neighbors, coworkers, acquaintances) | * MH measured as self-reported MH, past year MH, past 30 day psych distress. * Social capital (SC) measured as sense of belonging and workplace social support. * IV approach: Z is the family history of MH problems. * Why IV? Simultaneity between SC ⬄ HC and MH. Measurement error in self-reported MH (people who feel bad may report feeling worse than necessary)   MH 🡪 social capital   * MH better measured through diagnoses and not short term symptoms * Endogenous: MH * Highly correlated with family history because of heritability | See referenced papers:  *How social capital affects health*   * Ehsan e De Silva 2015 * Rodgers et al 2019 literature review   *Social capital as a production factor of health*   * Laporte 2014 (paywall) * Sirven Debrand 2012 🡪 uses SHARE?   *MH effect on labor market outcomes*   * Banerjee et al 2017 |
|  | Bell 2014, *Life-course and cohort trajectories of mental health in the UK, 1991e2008 e A multilevel age-period-cohort analysis* |  |  |  |
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|  | **#LONELINESS #SHAREDATA #COVID-19** | | | |
| 4 | Fokkema et al. 2012, *Cross-national differences in older adult loneliness* | * Share data (W2) * Logistic model * Older adult loneliness: not married, economic deprivation, poor health are predictors of loneliness. Contact with parents, adult children, social participation, support to family members were important in prevention and alleviation of loneliness. | * Levels of loneliness differ across societies. North-South gradient: older people in northern countries in EU are less lonely than southern peers. Generally found (Jylha & Jokela, 1990; Sundstr ¨ om, Fransson, Malmberg, & Davey, 2009; Walker, ¨ 1993) * Specification: * Geo indicators: north, south, west, central Europe. * Explanatory factors: demographic, socioeconomic, health and social networks. * Social trends affecting loneliness: * More old adults live alone * Marital support is good for physical and mental well-being * Living alone is bad for network connections, outreach to people and social iniziative * Gender differences: older women more likely to be widows * Increasing rates of divorce and remarriage * Linked to secularization and individualization * Increase in life expectancy: more years with disability, shrinking social networks because of death of peers * Northern euro countries were the first to experience these trends * Pension schemes, social security and healthcare are ways to enhance self-reliance of old people * **Loneliness (subjective) =/= social isolation (objective)** * *Demographic differences in countries* affect loneliness: * Age, gender and marital status composition matter * Loneliness increase with age (>75), more common among older women (widowhood), and being unmarried. * Low socioeconomic status (education and income) associated with higher loneliness. * Less friends, lower quality of connections, social exclusion. * *Based on their less favorable social status, we expect relatively high proportions of lonely older adults in the central and southern European countries of Poland, the Czech Republic, Greece, Spain, and Italy (H2)*. * Health (physical and mental) and loneliness are related. Reluctance to see doctor, seek help, remembering to take medication. * Countries are different in the size and composition of social networks. Northern countries have fewer expectations about community. *Contact with friends and participation in volunteering and social clubs is* ***lower in more collectivistic countries***. * No data on the size and composition of social networks in W2. Might be present in W8.   Method:   * Use longitudinal data from SHARE (SHARELIFE) * Loneliness measured from the CES-D (depression) scale. Binary value =1 if person felt lonely during past week. * Demographic characteristics: age, gender, marital status. * Socioeconomic status: education, employed, perceived difficulty with current income. * Health: perceived health, functional limitations (ADL, IADL), sight or hearing impairment. * Social embeddedness: has children, how often they have contact with them (1-4), has parents, parents’ health, social participation. * Support exchange: gives regular help with personal care given in households, informal help given to people outside household and to whom (family, non family), looking after grandchildren, informal help received.   Results:   * Descriptive stats * Multivariate logistic regression * Model 1 provides the basic differences in loneliness between countries * Model 7 of Table 3 provides an overview of the loneliness rate in the 14 European countries after we took into account country-level differences in demographic characteristics, wealth, health, social embeddedness, and support exchange. in Model 7 only two countries have significantly higher levels of loneliness: Italy and France. * As regards France, the frequent reports of loneliness among their older residents might be a methodological artifact. As regards Italy, part of the explanation lies in economic deprivation and poor health in the older adult population. * High levels of loneliness in Spain, Italy, the Czech Republic, and Poland are largely associated with financial and health problems among their older adult population | * No data on the size and composition of social networks in W2. Might be present in W8.   NOT METHODOLOGICALLY USEFUL.  GOOD FOR LITERATURE REVIEW. |
| 4 | Niedzwiedz et al. 2016, *The relationship between wealth and loneliness among older people across Europe: Is social participation protective?* | * SHARE W5 (2013), not sharelife * Logistic model * Loneliness is highest in poorest groups, lowest for the richest. | * Aims: * Examine the relationship between household wealth, social participation and loneliness. * Investigate whether relationships vary by type of social participation (charity/volunteer work, sports/social clubs, educational/training course, and political/community organisations) and gender. * Examine whether social participation moderates the association between wealth and loneliness   Method:   * Loneliness was measured using the short version of the Revised-University of California, Los Angeles (R-UCLA) Loneliness Scale * Multilevel logistic model stratified by gender.   Conclusion:   * Participation in external social activities may help to reduce loneliness among older adults and potentially acts as a buffer against the adverse effects of socioeconomic disadvantage * least wealthy older people experience greatest risk of loneliness and they are also less likely to participate in formal social activities compared to wealthier individuals * Frequent participation in formal social activities also moderated the relationship between household wealth and loneliness, suggesting that for socially-disadvantaged groups, taking part in external activities may act as a buffer against experiencing loneliness, particularly among men * for both genders, being involved in sports and social clubs, or volunteer/charity work was most strongly related to the reduced likelihood of loneliness, compared to other social activities | * considered wave did not contain info on religious association |
| 0 | Luchetti et al 2019*, Loneliness is associated with risk of cognitive impairment in the Survey of Health, Ageing and Retirement in Europe* | * SHARELIFE data on loneliness and cognitive impairment to evaluate their relation * test whether the association varies by age, sex, education level, and marital status * w2 – w6 | * Feeling lonely was associated with increased risk of incident cognitive impairment (HR = 1.31, 95%CI = 1.19-1.44), after accounting for age, sex, education, and SHARE country strata. * The association was robust but reduced in magnitude when controlling for clinical and behavioral risk factors, health-related activity limitations, social isolation, social disengagement, and depressive symptoms. * *The association was* ***not*** *moderated by socio-demographic factors and was also apparent when using the three-item loneliness scale instead of the single-item measure* * Loneliness and alzeihmers and dementia * Increased dementia risk, robust to controlling for social isolation, depression and other clinical and behavioral factors that impact cognition. * Factors that mediate **loneliness-cognition relation**: * Less healthy behavior * More likely depressed * Preventable?   Longitudinal data: 11 years follow up.   * Controls: social isolation/disengagement, health related activity limitations, depressive symptoms, and other behavioral and clinical risk factors for cognitive impairment and dementia.   Measure of loneliness:   * Center for Epidemiological Studies Depression scale * Three-item UCLA loneliness scale   Cognitive impairment:   * Memory task in SHARE, animal fluency task   Social isolation:   * indicators of social isolation: : being single, separated from spouse, divorced, or widowed (yes/ no), having rare contact with children or no children (yes/no), and household size (3+ members, 2 members, or only 1 member). * Social engagement: voluntary or charity work, attended an educational or training course, gone to a sport, social or other kinds of clubs, or taken part in a political or community-related organization.   Covariates:   * Age (years), sex (0 = male, 1 = female), and educational level (from 0 = Pre-primary education to 6 = Second stage of tertiary education) * clinical and behavioral covariates, health-related activity limitations, and depression symptoms * BMI, hypertension (y/n), diabetes (y/n) * Global Activities Limitation Index * EURO-D depression scale (depressed mood, pessimism, suicidality, guilt, troubles with sleep, loss of interest, irritability, change in appetite, fatigue, concentration, enjoyment, and tearfulness) * two dummy-coded variables to detect transition into widowhood (yes/no) and increases in health-related limitations (yes/no) over the follow-up 🡪 potentially increase risk of cognitive impairment   Strategy:   * Cox regression hazard models were used to test whether loneliness at baseline was associated with incident cognitive impairment over up to 11 years of follow-up * used because it evaluates time-to-event from baseline predictors   Findings:   * For every one-point increase in loneliness, there was a 31% increased risk of cognitive impairment over the follow-up, after controlling for age, sex, and education * The association was robust and remained significant (though reduced) when accounting for indicators of social isolation/disengagement, health-related limitations, and depressive symptoms. It was also significant after accounting for widowhood and changes in health status over the follow-up. Moreover, the association did not vary by age, sex, education, nor marital status * In our sample, the association between loneliness and cognitive impairment was reduced in size when accounting for risk factors such as depressive symptoms | * Loneliness – Alzheimer’s / dementia association * Boss L, Kang D-H, Branson S. Loneliness and cognitive function in the older adult: a systematic review. Int Psychogeriatr. 2015;27(4):541- 553. https://doi.org/10.1017/S1041610214002749. 3. * Wilson RS, Krueger KR, Arnold SE, et al. Loneliness and risk of Alzheimer disease. Arch Gen Psychiatry. 2007;64(2):234-240. https:// doi.org/10.1001/archpsyc.64.2.234. 4. * Sundström A, Nordin Adolfsson A, Nordin M, Adolfsson R. Loneliness increases the risk of all-cause dementia and Alzheimer's disease. J Gerontol Ser B. 2019;gbz139. https://doi.org/10.1093/geronb/gbz139. |
| 5 | Lee 2020, *Loneliness among older adults in the Czech Republic: A socio-demographic, health, and psychosocial profile* | * SHARE w6 of Czech >65yo * Descriptive stats, ANOVA and regression analysis * Studies relationships between loneliness and health, social network measures, subjective and psychological well-being | Findings:   * Demographic variation was substantial with the sample of the Czech elderly. The widowed, divorced, and young-old were significantly related to higher loneliness. A U-shaped association was identified between household size and loneliness. Loneliness was also significantly related to education levels and types of living area, but in a complex non-linear way. In contrast, there was no gender difference. Regression results indicated that poor health conditions and social environment were significantly associated with Czech elderly’s loneliness. Loneliness appeared to be linked to subjective and psychological well-being among Czech older adults   **Reverse causality issue:**   * Stroke, diabetes and cardiometabolic health conditions 🡪 cause loneliness * Lonely people have more chronic illness, motor impairment, doctor visits. * According to Litwin and Shiovitz-Ezra (2010), different types of social network appeared to be linked to loneliness, anxiety, and happiness: the greater social capital, the better well-being * *the importance of loneliness should be amplified by its impact on subjective well-being and quality of life outcomes*   Measurement:   * loneliness measured with UCLA loneliness scale. Multi idem index of loneliness was created as the sum of responses to individual items. * Controls: health variables (chronic disease, BMI, pain, self rated health, ADL index, physical activity engagement. * Five social network quality and quantity indicators: number of social network, avg contact with network, emotional closeness to social network. * SN is partner, children, parents, siblings, friends, neighbors, formal help or others. * Self reported satisfaction with SN * Measure of subjective well being uses 2 indexes: CASP12 scale, life satisfaction. * EURO-D scale for mental and emotional health of respondents.   Interesting thing in descriptive stats:   * Living in rural area associated with less loneliness.   Health and loneliness (not causal, very endogenous):   * Loneliness significantly related to health: poor health, chronic disease, pain, limitation of activity, lower engagement in sports or other activity. * Volume of social network and loneliness are positively associated. | * Focus on Czech elderly is too specific * Methodologically not innovative, barely relevant   Good for literature review.  WARNING: no mention of reverse causality or endogeneity when doing regression analysis 🡪 results are not causal.  TERRIBLE PAPER   * Shiovitz Ezra 2010 the role of social relations in predicting loneliness (social network 🡪 loneliness) |
| 4 | [SHORT REPORT] Jarach et al (2021), *Social isolation and loneliness as related to progression and reversion of frailty in the Survey of Health Aging Retirement in Europe (SHARE)* | * Relation between frailty and loneliness * SHARE w5-w6 | * Average levels of loneliness or social isolation were reported by a quarter and two thirds of the population, respectively. * Avg and high level of loneliness worsens frailty risk * High loneliness prevents remission   Measurements;   * UCLA loneliness scale * Social isolation score built from other Y/N variables: * Unmarried/cohabiting * Less than monthly contact with child * Not doing voluntary or charity work, or organization, classes, groups, club etc   Methods:   * Relative risk ratio (RRR) and confidence intervals * Multinomial logistic regression   “Our findings indicate that tackling social aspects of the life of frail and pre-frail people can reverse their condition” 🡪 it does NOT because of unaddressed endogeneity | WARNING: method is weak, not causal results, no mention of reverse causality  TAKEAWAY: loneliness is not social isolation. |
| 2 | Santini, Koyanagi (2021), *Loneliness and its association with depressed mood, anxiety symptoms, and sleep problems in Europe during the COVID-19 pandemic* | * Medical paper * COVID19 (but in 2020) * Aim: * risk of mental health problems (depressed mood, anxiety symptoms, sleep problems) associated with loneliness during COVID-19 * worsened loneliness 🡪 MH * worsened MH 🡪 loneliness * SHARE w6 (?) | * In 2017, The World Health Organisation’s Global Burden of Disease Study has identified depression as being the single largest contributor to global disability across all diseases, and anxiety ranking sixth * Depression and anxiety in older adulthood are major public health issues 🡪 high prevalence and poor outcomes, impairment in various types of functioning, self neglect and risk of premature mortality and suicide * Loneliness is likely to have accumulated during the pandemic due to mobility restrictions, quarantines, social distancing, and the like   Outcomes:   * (a) any depressed mood; (b) worsened depressed mood; (c) any anxiety symptoms; (d) worsened anxiety symptoms; (e) any sleep problems; (f) worsened sleep problems   Predictors:   * Loneliness and worsened loneliness   Controls:   * country, gender, age, marital/partnership status, employment status, income, financial strain, self-rated health, and anyone close to the respondent having died due to COVID-19   Method:   * Multivariate logistic analysis   Results:   * The prevalence of depressed mood, anxiety symptoms, and sleep problems were 28.6%, 30.4%, and 27.3%, respectively * Worsening among these conditions being 63.5%, 73%, and 34.6%, respectively * The prevalence of loneliness was 29.4% and among those reporting loneliness, the prevalence of worsened loneliness was 39.9% * Loneliness and worsened loneliness were both associated with significantly higher odds for any depressed mood, any anxiety symptoms, and any sleep problems * Worsened loneliness was significantly associated with particularly strong risk for worsened depressed mood, anxiety and sleep problems * People who already had MH issues were much more at risk | * Explores the relation between loneliness and MH with logistic regression in both directions, but in neither does it account for reverse causality (WARNING) * Notices that timing of interview during 2020 affects results: * Wave collected in a period (Jun/Aug 2020) when restrictions were less strong on average than previously or afterwards 🡪 results may be even stronger if collection was done before/after |
| 1 | Arpino et al (2022), *Loneliness before and during the COVID‑19 pandemic—are unpartnered and childless older adults at higher risk?* | * Mitigation efforts might worsen loneliness for unpartnered and childless older adults. * SHARE w8 and SCS1 (corona survey) * Logistic regression model for two binary outcome measures | * concerned about loneliness among older adults, potentially driven by shifts such as decreasing fertility, the increasing prevalence of living alone, and other factors, especially in the United States and Europe * (Aartsen and Jylha 2011; Dahlberg et al. (2022); Holt-Lunstad 2017; Holt-Lunstad et al. 2015; Klinenberg 2016; National Academies of Sciences, Engineering, and Medicine 2020; Verdery et al. 2019; Zoutewelle-Terovan & Liefbroer 2018) * This is particularly a concern for older adults who do not have traditional family ties—like partners and children * (Greenfeld and Russell 2011; Hazer and Boylu 2010; Fokkema et al. 2012; Margolis et al. 2021; Zhang and Hayward 2001) * Loneliness is not social isolation. See paper for references on how smaller social network is a risk factor for loneliness. * *Older people suffered less form increased loneliness during covid*. * Overall, existing studies on COVID-19 and older adults’ loneliness cross-nationally are difficult to compare due to wide variation in study designs in terms of sampling strategies and social contexts (e.g., local, regional, country variation in policy and COVID-19 mitigation strategies). * unpartnered and childless older adults typically have broader networks of extended kin and non-kin ties which may have been more vulnerable to disruption during COVID-19 compared to partner and child ties   Measurement:   * Loneliness: feeling lonely and feeling more lonely during the pandemic 🡪 first indicator of loneliness * the group who felt lonely “often” or “some of the time” received an additional follow-up question during the pandemic (SCS1), asking if they felt *more* lonely during pandemic 🡪 second indicator of loneliness   Explanatory variables:   * Partnership and parenthood status, measured with dummy variables   Controls:   * Sex, age, education, employment, country * Self-reported health, global activity limitation index (GALI)   Results:   * prior to the pandemic, unpartnered parents had the highest risk of loneliness * being unpartnered during the pandemic was associated with a higher likelihood of becoming lonely * being unpartnered and childless were associated with a higher likelihood of staying lonely during COVID-19 * **Increased loneliness during the pandemic, especially for unpartnered and childless** | * Plümper T & Neumayer E (2020) Lockdown policies and the dynamics of the frst wave of the Sars-CoV-2 pandemic in Europe. J Eur Public Policy, 1–21   GREAT FOR LITERATURE REVIEW.  RELEVANT METHODOLOGICAL NOTES:   * “We excluded observations from **Portugal** (because Portugal started the fieldwork of the regular wave 8 only a few weeks before the start of the first lockdown due to the pandemic” * “Data from **Austria** have been removed in a robustness check due to different timing of their SCS1 data collection (July–September).”   FUTURE RESEARCH QUESTIONS TO EXPLOIT:   1. examine additional well-being outcomes, such as anxiety and depression, among childless and unpartnered older adults during the pandemic. 2. future work should explore in-depth information about social interactions (e.g., care and help received, social contacts including digital ones) that may mitigate potential social isolation 3. whether the pandemic levels or reinforces gender differences in loneliness by parenthood and partnership status identified in prior research (Greenfeld and Russell 2011; Zhang and Hayward 2001) 4. Some countries start off less lonely than others: study the cross country differences in the changes in loneliness during the pandemic |
| 0 | Atzendorf Gruber (2022), *Depression and loneliness of older adults in Europe and Israel after the first wave of covid‑19* | * SHARE corona survey & w8 + macro data from Oxford COVID19 Government Response Tracker (n of deaths per 100000 and n of days with stringent control measures) OxCGRT * Study mental health of older adults (loneliness and depression) * we look at the weeks afterward in order to measure the medium-term consequences of the first wave and the lockdown measures on the mental well-being of older people * retired population >60yo * multilevel binary logistic regression models (individual and country level) + country FE | * Restrictions mean more MH deterioration especially for old and living alone people * MH problems associated with morbidity and mortality in long term, especially for older people (Holt-Lunstad et al 2015) * For old people: cardiovascular, immune and neurocognitive disease (Gerst-Emerson and Jayawardhana 2015) * Krendl and Perry (2020) higher levels of depression and loneliness than they had prior to the pandemic in the US * Same in the US Killgore et al. 2020 study, and in China (wang et al 2020), in Netherlands (Van Tilburg et al 2020) MH remained quite stable * Kim and Jung (2020) show that *distress* with the pandemic is associated with the stringency of policy measures. * Tillburg et al (2020): avg *social* loneliness increased slightly, avg *emotional* loneliness increased strongly.   What influences loneliness?   * Age differences in loneliness * Living arrangements are an important factor (Luhmann and Hawkley 2016, Germany). Unmarried and living alone. * Fokkema and Knipscheer (2007) argue that internet and communication tools (social networks) may ease loneliness in older people * Fingerman et al (2020) in person contact might have non transferable benefits to electronic contact. Krendl and Perry (2020) find that electronic communication does not offset older adult loneliness.   Data:   * Malta excluded because not in OxGRT dataset   Measurement:   * Binary variable for loneliness using corona survey * Binary variable for depression   Individual explanatory variables:   * Age 60-69, 70-79, >80 * Household size * Frequency of social contact (in person, electronic) with children, parents, relative and non relative   Macro explanatory variables:   * N of days with stringent measures * N of cumulated deaths per 100k inhabitants * Political indicators: school closings, workplace closings, canceling of public events, restrictions on gathering size, closing public transport, stay-at-home requirements, restrictions on local movement, and restrictions on international traveling 🡪 stringency index 0-100 from OxGRT   Controls:   * Health worsening * Covid19 infection themselves or of close person * Gender, educ, martial status, financial hardship   Dependent variables:   * Feeling more depressed and feeling lonelier   Method:   * Multilevel binary logistic regression * AIC and BIC for goodness of fit * Median Odds Ratio to measure heterogeneity between countries (MOR>1 means living in countries may explain depression/loneliness)   Logistic regression results:   * Personal contact 🡪 less sad/depressed since outbreak * Electronic contacts 🡪 more likely to be sad/depressed * Cumulated deaths and n of days with stringent measures are associated with feeling sad/depressed * *Depression increases by 20% within 30 days with high stringency measures. If the number of deaths due to COVID-19 would increase by 50 in 100,000 inhabitants, feelings of depression and sadness would increase by 54*% * While feelings of loneliness are on average not significantly increasing with number of deaths, they are for those with more frequent personal contacts * the results cannot be interpreted causally but rather as correlations | Hypotheses are very well stated:  H1a: Number of deceased and the stringency of policy implications account for country variation in depression and loneliness  H1b: Both the general situation of the pandemic, approximated by the number of deceased, and the duration of stringent policy measures have a significant influence on older people’s well-being at the micro-level.  H2: The oldest age group and those living in single households have an increased risk of intensified feelings of depression and loneliness after the first COVID-19 wave  H3: Electronic contacts do not significantly reduce the risk of feeling more depressed or lonely as a consequence of the pandemic |
| 1 | Hajek, Konig (2022), *Which factors contribute to loneliness among older Europeans? Findings from the Survey of Health, Ageing and Retirement in Europe Determinants of loneliness* | * SHARE w5 – w7 * Linear FE regression * What are determinants of loneliness? | Method:   * Loneliness was assessed using the three-item loneliness scale. * As explanatory variables, we included age, marital status, income, self-rated health, depressive symptoms, functional decline, cognitive functioning and chronic diseases. * Exploiting the features of panel data and mitigating the problem of unobserved heterogeneity, linear FE regressions were used * Outcome is loneliness UCLA scale   Results:   * Loneliness increases with age, changing from married and living together to another status * Decreases with log income, self-rated health, functional decline * Increases in depressive symptoms * Decreases in cognitive functioning * Not associated with changing in chronic diseases (surprising, unlike Kristensen et al 2019)   Resources:   * Multimorbidity and the onset of obesity are associated with greater loneliness 🡪 Hajek and Konig 2019, Kristensen et al 2019 | * Does not use logistic analysis, good for me * Using FE eliminates time constant factors such as genetics, which would bias estimates.   MENTIONS ENDOGENEITY!!! |
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|  | **#GENERAL TOPICS** | | | |
| 4 | Shiovitz-Ezra, Leitsch (2010), *The Role of Social Relationships in Predicting Loneliness: The National Social Life, Health, and Aging Project* | * associations between objective and subjective social network characteristics and loneliness in later life * Data from National Social Life, Health, and Aging Project (47-85yo in US), NSHAP w1 * Hierarchical linear regression * Predict loneliness across marital status | * Cognitive theory 🡪 **Loneliness**, according to this theoretical point of view, results from the perceived discrepancy between desired and actual social relationships or the subjective gap between one’s optimal levels of social relationships and achieved levels of same * Rising phenomenon and has effect of physical and MH * Loneliness suicide in Stravynski and Boyer 2001 * two domains of the social network form the most likely determinants of loneliness among older adults: * network size and frequency of interaction * quality of social ties measured subjectively * social interaction can also be negative: Rook and Pietromonaco 1987, Ryehlman and Wolchik 1990   measurement:   * loneliness using revised UCLA (R-UCLA) shorter from 20 item to 3 item * social network measured as: marital status, n of children and grandchildren, n of relatives and friends, frequency of social contact with categories. Subjective measures of SN satisfaction.   Covariates:   * health status as self reported * sociodemographic data (gender, educ, ethnicity, subjective relative income)   Method:   * Correlations between predictors and loneliness * Hierarchical linear regression to examine the association between measures of objective/subjective SN and the importance of each domain in predicting loneliness * Compute differences in R^2 …   Results:   * The direction of the relationships between the subjective network characteristics and loneliness were as expected * concerning relatives and friends, the negative characteristics more dominantly associated with loneliness * *negative* aspects of social relations are stronger predictors | * Method not very good: uses differences in R^2 to determine if a model is better than the other. * Overall, they find subjective measures to be better predictors of loneliness than objective measures.   CORRELATIVE STUDY, NOT CAUSAL. |
| 1 | Sirven Debrand 2012, *Social capital and health of older Europeans: Causal pathways and health inequalities* | * SHARELIFE * Studies the Granger causality between health and social capital for older people in EU * W1 – W3 * Bivariate recursive probit model to investigate the influence of baseline social capital on health and the impact of baseline health on current participation in social activity | * Reverse causality between social capital and health: * Social capital 🡪 health is weaker * Health 🡪 social capital is very strong   Social capital:   * Enhances the diffusion of health information * Fosters healthy behavior * Improves mental health   Methodological approach:   * A time-based approach (à la Granger) is considered in which a two-equation recursive model is used to simultaneously investigate (i) the influence of baseline social capital on current health e controlling for baseline health and other current covariates, and (ii) the impact of baseline health on current participation in social activities – controlling for baseline social capital and other current covariates   Measurement:   * Social capital indicators: * Dummy for involvement in social activities derived from participation in voluntary/charity work, training course, sport/social club, religious organization, and political/community organization * Health measures: * Poor self-rated health (SRH) * Reporting limitations in ADL’s * Limitations with activities (GALI) * Limitations with mobility, arm function and fine motor function * Low grip strength * Depressive symptoms (EURO-D scale) * Relative cognitive impairments (memory test and executive functions test) * Covariates: age (in class), gender, education (highest diploma obtained), living with spouse or partner, labor market status (employed), log of household net income per consumption unit (corrected for Purchase Power Parity), and country dummies * Special attention was dedicated to the following variables: being born in the country of residence; reporting a better relative performance in math and language at school when aged 10; having been in a hospital for more than a month before the age of 10; self-rating own health at 10 years old excellent or very good; having encountered periods of poor health before the age of 10; an index of the features of accommodation when aged 10 (ranging from (0) poor to (6) comfortable); the log of the number of moves from one accommodation to another so far; having ever worked in a voluntary association before the start of wave 1; and, a variable of household size when aged 10 🡪 initial conditions influence and life-course experience effects   Why not use IV?   * However, the instrumental variables (IV) estimators do not make clear if the influence of social capital on health could be overestimated (Folland, 2007), underestimated (Rocco & Suhrcke, 2008)   MODEL:     * Sample selection issue: individual health H or social participation D are not randomly distributed across the sample * Entanglement of state dependency and individual heterogeneity is also an issue. Would make parameters inconsistent. * Solve with Mundalak specification: parametrize the individual effect by inserting the average value of the covariates over the time span in the equations. * Final model: * Since t ¼ 2 in our case, the model can be estimated by Maximum Likelihood with a standard bivariate Probit routine   Results:   * Healthy worker effect: more healthy people will have higher change of being economically active. Healthy means less poor self rated health, limitation with activities, limitation with mobility and depressive symptoms. * Living with spouse/partner reduces depressive symptoms and poor self rated health * Richer people have lower propensity to be in poor health * Country dummies matter 🡪 north south gradient in participation in social activities (more participation in the north) * Probability of being involved in social activities increases from 50-65 (retirement and more free time), decreases with older ages (worse health) * Education is strongly associated with social capital * Gender differences have low explanatory power * Income does not appear to be a significant determinant of social participation   Robustness checks:   * Change thresholds for health variables (not for mental health) * Second, we wanted to check whether the main influence of social participation was actually due to physical activity since “sport clubs” belongs to one of the categories of the social activities in SHARE   *Does social capital contribute to better health?*   * Dynamic recursive Probit models suggest that taking part into social activities in 2004e05 significantly reduces the chances of poor health in 2006e07 for SHARE respondents, in 11 European countries, once we control for baseline health and the usual current covariates * No significant effect was ever found here in the case of low grip strength.   *Does social capital contribute to health inequalities?*   * Our findings indicate that the average causal effect of social participation on health is always significantly smaller than the “feedback effect” from health on social participation. * According to robustness checks based on changes in cutpoints in health measures, it appeared in some cases that social participation may have decreasing returns on health. | * Very good paper. * Good methodological approach. |
| 1 | Luo et al (2012), *Loneliness, health, and mortality in old age: A national longitudinal study* | * estimated the effect of **loneliness** at one point on **mortality** over the subsequent six years, and investigated social relationships, health behaviors, and health outcomes as potential mechanisms through which loneliness affects mortality risk among older Americans * adopts cross lagged panel models and autoregressive and cross lagged paths to solve the reverse causality issue * All models were estimated using Full Information Maximum Likelihood estimation with robust standard errors | * explore relation between loneliness mortality health in the US for >50yo 2002-2008 * outcomes: depressive symptoms, health self rated, functional limitations * In cross-lagged panel models that tested the **reciprocal prospective effects of loneliness and health**, loneliness both affected and was affected by depressive symptoms and functional limitations over time, and had marginal effects on later self-rated health * Health (emotional, physical, functional) is a predictor of mortality and thus test for longitudinal effects of loneliness   Loneliness and mortality.   * Our conceptual model posits that the influence of loneliness on mortality is attributable to the relationships between loneliness and social isolation, unhealthy behaviors, and poor health * Our theoretical model of loneliness holds that loneliness activates implicit hypervigilance for social threat in the environment * Chronic activation of social threat surveillance diminishes executive functioning, and heightened impulsivity influences the tendency of individuals to engage in health behaviors that require self-control * introduce emotional, physical, and functional health as additional mechanisms that may explain the association between loneliness and heightened risk of mortality   loneliness and emotional, physical and functional health   * Beyond cross-sectional associations between loneliness and depressive symptoms, loneliness leads to increases in depressive symptoms in longitudinal U.S. studies (Cacioppo et al., 2010; Hagerty & Williams, 1999; Wei, Russell, & Zakalik, 2005) * Loneliness is associated with poor physical health (Segrin & Domschke, 2011; Stephens, Alpass, Towers, & Stevenson, 2011). * loneliness and increases in loneliness over time predict decrements in self-rated health (Nummela, Seppänen, & Uutela, 2011) * Physical activity is important in maintaining higher levels of physical functioning (Keysor, 2003; Lee & Park, 2006; Netuveli, Wiggins, Montgomery, Hildon, & Blane, 2008), and because lonely individuals are less likely to engage in physical activity than their non-lonely counterparts (Hawkley et al., 2009), they are more likely to experience the onset or worsening of limitations * Our analyses allow reciprocal relationships between loneliness and each health outcome, thus providing more rigorous assessments than previous studies of the causal directions between these variables   Method.   * Data mainly come from the 2002, 2004, 2006 waves of the Health and Retirement Study (HRS) * Loneliness measured as: HRS asked how often the respondent feels (i) lack of companionship, (ii) left out, and (iii) isolated from others. * Mortality was determined through matching to the National Death Index or from contacts with household members through 2008 * Health outcomes. Depressive symptoms, self-rated health, and functional limitations were measured in 2002, 2004, and 2006 * Depression is conceptually related to but distinct from loneliness (Cacioppo et al., 2010) 🡪 **deleted items in the CES-D scale that overlapped with the measurement of loneliness** (“I felt lonely”, “sleep was restless”…) * Our measures of social relationships include marital status, presence of relatives living nearby, and presence of friends living nearby * Measures of health behaviors include sleep quality, physical exercise, current and past smoking * Sociodemographic include age, gender, race/ethnicity, education, household income and household assets   Estimation.   * The parametric models produced more efficient estimates than semiparametric (Cox) hazard models * and the Weibull distribution was the most efficient and parsimonious functional form for our sample data based on the Akaike Information Criterion * The survival analysis indicates whether loneliness affects mortality risk and the degree to which this effect is reduced when we hold constant measures of health status, possible mechanisms through which loneliness affects mortality * **However, because loneliness and health status were measured at the same time, the causal directions between them cannot be established**. For this reason we turned next to **cross-lagged panel models** and estimated **autoregressive** and cross-lagged paths * All models were estimated using Full Information Maximum Likelihood estimation with robust standard errors * FIML produces consistent and efficient estimates when the data are “missing at random” (MAR) and produces less biased estimates than other methods when the data deviate from MAR * We estimated separate cross-lagged path models for loneliness and each health outcome. * Our theoretical models assume that prospective relationships between variables are stable over time. These assumptions were modeled by applying equality constraints to the autoregressive and cross-lagged paths, thereby imposing “stationarity” on the relationships among variables in the model   Results.   * Mortality analysis showed that health outcomes assessed at the same time as loneliness helped explain the effect of loneliness on mortality, but did not permit evaluation of the causal direction between loneliness and health * Using cross-lagged models, we found that loneliness predicted increases in depressive symptoms, modest decreases in self-rated health and increases in functional limitations over two years even when the reciprocal effects of these health measures on loneliness were taken into account * Possessing a richness of social attachments and friends protects against mortality (House et al., 1988), and generally signifies lower levels of loneliness but we found that these objective characteristics of respondents’ social lives did not explain much of the effect of loneliness on mortality risk * The effects of loneliness on self-control suggest that health behaviors may differ as a function of loneliness and help explain mortality differences. This reasoning did not find support, however. * The fact that **loneliness continues to predict health outcomes when health behaviors are held constant suggests that loneliness alters physiology** at a more fundamental level | * Introductory literature review of the effect of loneliness is very good: both biological and behavioral references. Use them.   Note on the measurement of loneliness:  *This study used a 3-item composite index of loneliness which has been shown to have good validity and reliability (Hughes et al., 2004). This measure is an important improvement over previous studies on the lonelinessemortality relationship that measured loneliness with a single item asking respondents whether and/or how often they felt lonely. Specifically, our 3-item measure avoids use of the term “lonely” or “loneliness” and thus avoids much of the stigma associated with and consequent underestimation of loneliness. Nevertheless, the fact that mean loneliness levels were higher in 2006 than in 2002 and 2004, and that this difference corresponded to a change from an interview-based to a selfadministered questionnaire leaves open the possibility that stigma may have resulted in an underestimation of loneliness in the interview-based data* |
|  | Murayama et al (2013*), Do bonding and bridging social capital affect self-rated health, depressive mood and cognitive decline in older Japanese? A prospective cohort study* | * How social capital affects health * Older Japanese | * Social capital distinguishes between * *Bonding SC* 🡪 people with similar characteristics share stronger bond. Reinforces exclusive identities and homogeneous groups. * *Bridging SC* 🡪 networks that bridge different social and ethnic groups that may share dissimilar identities. * Limitations of previous literature: * Do bonding and bridging social capital affect self-rated health, depressive mood and cognitive decline in older Japanese? A prospective cohort study * Second, the health outcomes included by previous studies were limited (self-reported) * most studies considering bonding and bridging social capital and health were conducted in Western countries   outcomes:   * Self rated health * Depressive mood * Cognitive decline   Measurement:   * Measuring bonding and bridging social capital 🡪 we focused on the (dis) similarity of relationships with regard to age, gender, and socioeconomic status (SES) |  |
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