Working with social isolation and loneliness in older people's mental health services

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Abstract

Isolation and loneliness are common problems in both older people and individuals with mental health problems. However, little research has focused on how these issues might be addressed in clinical practice with older adults with complex mental health problems. Here we set out to understand how social isolation and loneliness present and how they could be better addressed from the perspective of older adults with complex mental health problems and the clinicians working with them. Semi-structured interviews were conducted with nine healthcare professionals and 11 service-users from an older people's mental health team and analysed using reflexive-thematic analysis. Results showed that professionals found social isolation easier to understand and work with than loneliness and tended to address *both* issues by targeting behaviours (i.e. what service-users could *do* differently). The psychological dimensions of loneliness (i.e. service users' thoughts and feelings) received less attention, although service-users emphasised these aspects. Other themes included the challenges faced by professionals in fostering social connections because of limited resources. We conclude that a greater awareness of the psychological dimensions of loneliness in older people with complex mental health problems is needed, as well as the resource challenges faced in creating social connections beyond mental health services.

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Introduction

Loneliness and social isolation are associated with poorer mental health, especially depression (Lee et al., 2021), and peak in young adulthood and later life (Victor & Yang, 2012). Social isolation and loneliness are related but distinct. While social isolation refers to a quantifiable reduction in the size of one's social network and/or frequency of social contact, loneliness is an emotional state resulting from a perceived discrepancy between existing and desired relationships. Interventions targeting social isolation do not necessarily affect loneliness (Ma et al., 2020).

Research suggests that the most effective interventions for isolation amongst people with mental health problems centre around supported socialisation (e.g. peer support), and for loneliness, interventions targeted at unhelpful thoughts related to the self and others (e.g. Cognitive-Behavioural Therapy, CBT) (Ma et al., 2020). Regarding interventions for *older people* more generally, research suggests that educational and social activity delivered in a group format have the greatest benefits for social outcomes (Dickens et al., 2011).

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However, little research has focused on what works in reducing loneliness and isolation for older people with more complex mental health problems, who typically present with multiple biopsychosocial problems, and greater degrees of chronicity and severity. In addition, although there is a wealth of quantitative data on the correlates of isolation and loneliness, there is little qualitative research which can help to uncover the processes that underpin routine practice (Umberson & Montez, 2010), and therefore assist with the implementation of interventions

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(Fakoya et al., 2020). The aim of this research is therefore to better understand how social isolation and loneliness present, and how they are addressed, in a secondary care older people's mental health team, both from the professional and service-user perspective. In particular, we sought to understand whether professionals and service-users distinguish between isolation and loneliness, and how practice compares with current best evidence for working with isolation and loneliness.

Methods

Participants

We conducted semi-structured interviews with service-users and healthcare professionals from an older people's mental health service in Cambridgeshire. Our secondary care service provides multidisciplinary treatment for people aged 65 plus with complex mental health problems. Sample size was based on a similar qualitative study (Hare-Duke et al., 2021) and information power (Malterud et al., 2015).

Eligible service-users and professionals needed to have been under, or worked for the team, for a minimum of three months. We recruited service-users who experienced depression as part of their presentation but had a range of primary diagnoses. We excluded service-users with a diagnosis of dementia, currently or recently in an acute mental health crisis, and service-users currently or previously receiving therapy from the lead researcher. Clinicians were asked to obtain consent from eligible service-users before being contacted by the lead researcher to discuss participation.

Data collection and analysis

All professionals were interviewed via video call. Five service-users were interviewed in person (clinic or home visit) and six via video call. The interview schedule was developed iteratively based on knowledge of the literature and in conversations with colleagues and a Patient and Public Involvement Panel. Interviews were audio recorded, transcribed and anonymised.

Professional and service-user transcripts were analysed separately using NVivo12. Data was analysed using Reflexive-Thematic Analysis (R-TA) (Braun & Clarke, 2021).

Ethical approval for the study was obtained from the Health Research Authority and Health and Care Research Wales (Research Ethics Committee ID: 22/YH/0180).

Results

Participants

Eleven service-users and nine professionals participated. Service-users' mean age was 71 (range: 66 to 76), seven were female (four male) and all identified as White British. Professionals came from occupational therapy (n = 3), psychology (n = 2), nursing (n = 1), psychiatry (n = 1), social work (n = 1) and support work (n = 1).

Themes: Professional interviews

The need to be time-limited and community focused

Professionals were conscious of increasing service-users' connections with the wider community and reducing "dependencies" on mental health services in the long-term. Typically, "dependency" on services was viewed as something to be avoided, and connection with the community as preferable.

> *She's got a high level of support from the neighbourhood team and my team really. So, but at some point, that has got to, you know, sort of lessen……to try and improve things for her, we want to try and get her out in the community more* (P3).

For some professionals, this caused some psychological dissonance, as though setting such boundaries with service-users felt at odds with a caring role.

> *Sometimes you do have to be a bit, I suppose a bit ruthless, and I guess you think well I'll discharge this person, will bounce back at some point* (P5).

Professionals spoke about a lack of community resources as a barrier to increasing social connections. Some professionals also raised concerns about a lack of groups tailored to people with more complex mental health problems.

> *They would benefit from going to a place that's got some activities where there's people, like-minded people……Those places don't exist anymore* (P6).

Isolation is more visible and 'workable' than loneliness

Overall, the distinction drawn by the interviewer between isolation and loneliness made sense to professionals, but it was unclear whether this distinction was routinely incorporated into clinical work. Typically, professionals seemed to find loneliness harder to identify and work with than isolation, usually in situations where the person felt lonely but was not isolated.

> *[Loneliness is] harder to pick up immediately. It's normally after, cause I think, you look at it from the outside and you think ohh, they're fine, they've got lots of support but actually what that person is looking for, it's not there* (P4).

Professionals also approached loneliness and isolation in similar ways. As described below, they were more likely to focus on solutions and behaviours, rather than thoughts and feelings associated with feeling lonely.

> *Sometimes you have to sort of just take a more practical approach to, OK, well, you, you know, you are married, and you have got somebody who's there all the time, but you do still feel quite lonely. So, we're gonna perhaps explore, you know, getting out a bit more* (P2).

Solutions and behaviours (rather than thoughts and feelings)

Professionals commonly focused on addressing social isolation and loneliness through behaviour change, for example going to a coffee shop. Although professionals considered thoughts and beliefs in their formulations of service-users' difficulties, they were not typically targeted in interventions.

> *So, I said, you know, you can possibly even try just sitting outside, for the garden, for the first few days, a week, and then maybe just walk around your garden* (P9).

Typically, loneliness and isolation were something to be changed or 'solved'. There was less emphasis on acknowledging or normalising difficult feelings associated with isolation and loneliness. For example, here a professional is talking about acknowledging feelings of loneliness in the context of bereavement.

> *It's just been around kind of giving that space to kind of explore it, to kind of acknowledge, acknowledge those feelings and let them be there rather than trying to kind of resolve them or get rid of them* (P7).

Themes: Service-user interviews

The importance of feeling affiliated

Service-users reported feeling a need to feel part of or connected to an individual or group. Elements of affiliation included affection, companionship, fun, and sharing common experience. Service-users spoke about connection to, or belonging with, varied people, including spouses, friends, community groups and healthcare professionals.

> *Cause they talk, they bring me into the conversations where nobody else did and when I go to this other one, they do, they talk to me, you know, I feel, I feel if I'm one of the group* (S3).

> *I could say anything to [HUSBAND] and and he could say anything to me and we'd talk about things and I don't have that trust in anybody, that's the thing* (S5).

Withdrawal from the social sphere was associated with a feeling of disconnection (as opposed to belonging and connection). In these situations, seeing and interacting with people was often described as unappealing or as a source of discomfort, fear or self-consciousness.

> *I'm frightened of people making demands on me, expecting me to be normal because I'm not. I've become, you know, an abnormal person* (S2).

> *I didn't want people to see me or talk to me because I didn't want to to see me in that state, that state that I was* (S1).

'Good enough': Feeling acceptable to self and others

Participants described issues with feeling acceptable to themselves and others. A sense of losing one's 'true self' was quite common, with participants suggesting they were not the person they once were. These feelings seemed to underpin a sense of disconnection or alienation from others.

> *Well, I'm not, just not the same person I used to be, I used to be outgoing, a bit outgoing, and wanting to see people and now I don't* (S2).

Some participants spoke about learning to be kinder to, or comfortable with, themselves. This was important for connecting with others, but it also predicated feeling content in one's own company.

> *I'm making great strides, but I'm not, I'm not lonely in the same way I was because I've started, now I'm more myself, I'm, I'm more at ease in my own company* (S8).

Occasionally participants described feeling accepted by others (in contrast to *self*-acceptance). Dimensions of this included feeling the other person was understanding and non-judgemental.

> *My adopted mother, I could talk to her about anything. And you never felt like, I never felt like I was being judged* (S5).

(Not) mattering: feeling (in)visible and (under)valued

Service-users spoke about valuing the feeling that one is, at the very least, visible to other people. Participants often described simple outings, where they could be around people, as uplifting. Such outings made them feel part of society, as opposed to feeling forgotten about at home.

> *It was every other week, it's now once a week but they take me to Asda and that makes me feel so much, it, the element, humanise, it makes me feel like a human being, you know, being in with people* (S7).

A sense that one 'mattered' was important to relationships. Dimensions of mattering included feeling noticed and listened to by others, having some responsibility to others, or an ability to make meaningful contributions.

> *I was very involved, I actually answered people's questions, I actually did stuff that helped them* (S6).

Another dimension of mattering seemed to be the perception of choice and control. This was associated with feeling better about oneself. In contrast, increased dependence (and therefore less choice and control), was typically described as negative.

> *And I suppose too, I, you know I'm fearful of, I'm fortunate, l, I'm very physically able, but I do know quite a few people, you know, who have for whatever reason, have a physical health problem, and needed more support from other people* (S9).

Discussion

Professionals were conscious of the need to create social connections beyond mental health services, likely stemming from the current emphasis on time-limited services. Creating connections with the community brought challenges for professionals because of limited resources in the service and wider community. This is concerning given that the best evidence currently for reducing isolation is supported socialisation (Ma et al., 2020).

Overall, professionals seemed to be able to more easily identify, and work with, isolation as compared to loneliness. Differentiating between isolation and loneliness did not appear to be routinely incorporated into clinical formulation or care planning. Isolation and loneliness are related, however interventions targeting social isolation do not necessarily affect loneliness (Ma et al., 2020). It is therefore important to consider and target loneliness in its own right. Loneliness might be less routinely considered in clinical settings because of a lack of distinction between isolation and loneliness, or because loneliness as a psychological state is less visible than isolation. This suggests the need for more routine monitoring of loneliness in these settings.

In general, professionals set behavioural goals when addressing isolation and loneliness. There was less emphasis on addressing thoughts and beliefs related to these states. Significantly, service-users' experiences of feeling disconnected were characterised by thoughts and beliefs related to the self (e.g. feeling unacceptable) and others (e.g. feeling accepted by others), highlighting the role of unhelpful cognitions. Cognitions regarding mattering, choice and control may be especially pertinent for older people, who due to events associated with ageing (e.g.,

retirement, frailty), as well as societal ageism (Centre for Ageing Better, 2020), may feel less able to make meaningful contributions.

Research has highlighted the cognitive and psychological dimensions of loneliness e.g. fears of not mattering (McComb et al., 2020) and low self-esteem (Dahlberg & McKee, 2014). Psychological interventions currently show promise for reducing loneliness (Hickin et al., 2021). CBT has been the most researched model, however other therapeutic models may hold promise. First, it is notable that service-user themes of affiliation, not mattering and feeling unacceptable have much in common with the social motivational systems at the root of Compassion Focused Therapy (CFT; Gilbert, 2014). Second, Acceptance and Commitment Therapy's (ACT) emphasis on acceptance may be especially relevant for older adults who face situations that are hard to change such as poor health (Hayes et al., 2012). Finally, the importance of the self-concept highlighted in this research suggests interpersonal therapies like Cognitive Analytic Therapy (CAT) might be helpful. More research is needed to establish the effectiveness of these approaches for loneliness in older people with mental health problems.

Finally, the emphasis placed on social support and affiliation by service-users suggests interventions to strengthen relationships with significant others would be helpful. Individuals with whom service-users felt a sense of belonging or affiliation varied, and efforts should be made to identify and improve the relationships that the person finds most meaningful. This might be particularly important for older people for whom quality of relationships may matter more than quantity (Victor & Yang, 2012).

Limitations

With a mean age of 71, most older people in the study were 'younger' older adults. The views of 'older' older adults (usually regarded as aged 80+), in which loneliness is more common, are therefore under-represented (Dykstra, 2009). Additionally, the service-user group was entirely White British. Although the ethnicity of the sample is a fair representation of the wider group of service-users under the team, the reported findings may not be generalisable to other ethnic groups.

Conclusions

We highlight that loneliness was harder to identify and work with than isolation, suggesting the need for more routine monitoring of loneliness in secondary care mental health services for older people. Greater consideration of the psychological dimensions of loneliness (i.e. thoughts and feelings) in formulation and care planning is also needed, alongside existing behavioural and solution-focused approaches.

Acknowledgements

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References

Braun, V. & Clarke, V. (2021). *Thematic Analysis: A Practical Guide* (1st ed.). SAGE Publications Ltd.

Centre for Ageing Better. (2020. *An old age problem? How society shapes and reinforces negative attitudes to ageing*. Available online at: https://www.ageing-better.org.uk/sites/default/files/2020-11/old-ageproblem.Pdf

Dahlberg, L. & McKee, K. J. (2014). Correlates of social and emotional loneliness in older people: Evidence from an English community study. *Aging & Mental Health*, *18*, 504–514.

Dickens, A. P., Richards, S. H., Greaves, C. J. & Campbell, J. L. (2011). Interventions targeting social isolation in older people: A systematic review. *BMC Public Health*, *11*, 647.

Dykstra, P. A. (2009). Older adult loneliness: Myths and realities. *European Journal of Ageing*, *6*, 91–100.

Fakoya, O. A., McCorry, N. K. & Donnelly, M. (2020). Loneliness and social isolation interventions for older adults: A scoping review of reviews. *BMC Public Health*, *20*, 129.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*, 6–41.

Hare-Duke, L., Dening, T., Oliveira, D. et al. (2021). Social connectedness in adults with mental disorders: Ecological validation of a conceptual framework for novel complex interventions. *Journal of Mental Health*, *30*, 333–340.

Hayes, S. C., Pistorello, J. & Levin, M. E. (2012). Acceptance and Commitment Therapy as a Unified Model of Behavior Change. *The Counseling Psychologist*, *40*, 976–1002.

Hickin, N., Käll, A., Shafran, R. et al. (2021). The effectiveness of psychological interventions for loneliness: A systematic review and meta-analysis. *Clinical Psychology Review*, *88*, 102066.

Lee, S. L., Pearce, E., Ajnakina, O. et al. (2021). The association between loneliness and depressive symptoms among adults aged 50 years and older: A 12-year population-based cohort study. *The Lancet Psychiatry*, *8*, 48–57.

Ma, R., Mann, F., Wang, J. et al. (2020). The effectiveness of interventions for reducing subjective and objective social isolation among people with mental health problems: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *55*, 839–876.

Malterud, K., Siersma, V. D. & Guassora, A. D. (2015). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*, 1753–1760.

McComb, S. E., Goldberg, J. O., Flett, G. L. & Rose, A. L. (2020). The Double Jeopardy of Feeling Lonely and Unimportant: State and Trait Loneliness and Feelings and Fears of Not Mattering. *Frontiers in Psychology*, *11*, 563420.

Umberson, D. & Montez, J.K. (2010). Social Relationships and Health: A Flashpoint for Health Policy. *Journal of Health and Social Behavior*, *51*, S54–S66.

Victor, C. R. & Yang, K. (2012). The Prevalence of Loneliness Among Adults: A Case Study of the United Kingdom. *The Journal of Psychology*, *146*, 85–104.

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