Loneliness: A call for community approaches

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It occurred to me, as I quietly extracted my crushed fingers from number 52's letter box, before leaving the driveway and closing the gate discreetly behind me, that I didn't have a clue who lived in that house. Or the next, or the next, for whom I repeated the furtive delivering of leaflets right along my street and back again, for people whom I live metres from but don't know anything of. Other than fearing the hostility from someone believing that my purpose was to clutter their recycling bin with yet another takeaway menu, it felt like I was trespassing into people's lives. Those gates seemed closed for a reason.

To me, as a white British professional female in my early 30's living in South London, it seems that man's home really is his castle. An entity to preserve and defend; to keep the feared 'others' out. Perhaps after jostling to fit an extra body inside the doors of the crammed 08.10 to Blackfriars (the 07.56 was cancelled. Again.), there is an even greater psychological need for space. Or perhaps it says something fundamentally important about our society, amidst headline reports that we are facing an 'epidemic of loneliness' (Khaleeli, 2013), the topic of this article.

Figures suggest that a growing number of people are living alone, with 30% of the UK population in 2011 recorded to be single occupants compared with 12% in 1961 (2011 census, the Office for National Statistics, cited in Maitland, 2014). Other factors outlined in a report published by the Mental Health Foundation titled 'The lonely society?' pointing towards greater psychological distance within relationships include rising divorce rates and lone parent families, greater separation from our extended families and communities of birth, an emphasis on 'busyness' as more important than social connectedness, and longer working hours meaning less time with loved ones (2010). The report suggests that our communities are changing, with local services disbanded, more urbanised ways of living and a greater reliance on modern technologies for maintaining relationships. This is not to suggest it's all bad- many of us at all ages of the spectrum would feel bereft should social media and programmes such as Skype cease to exist, with research suggesting that older migrants report modern technologies support a continued sense of connection with transnational communities (Li, Hodgetts & Sonn, 2014).

Overall, however, the picture seems to be one suggestive of increased separation. Isolation is not synonymous with loneliness, defined as the difference between the amount or quality of social contact that we would like, compared to what we actually have (Age UK, 2010). However, it is predictive of it (findings from the 2004 English longitudinal study of ageing, cited in Age UK, 2010).

Whilst loneliness might be an experience we have all been acquainted with at points within our lives, it is chronic loneliness- when it persists for such a time as to impact our thoughts, feelings and behaviours- that is particularly problematic (Mental Health Foundation, 2010). It is argued that those of us who are more cut off from society through factors such as mental health problems, long term physical health conditions, stigma and older age (Andersson, 1998) are more likely to be susceptible to experiencing chronic loneliness. It is evident that older people might be vulnerable to all the factors outlined, through, for example, bereavement and loss of socially valued roles, and figures suggest that between six and thirteen percent of the older population in the UK are consistently

lonely (Campaign to end loneliness, 2011), with 41% of all older people indicating their main source of companionship to be a pet or the TV (O'Connor, 2014).

The detrimental impacts of loneliness are psychological, cognitive and physical, and which include high blood pressure, falls, depression and suicide (see Campaign to end loneliness website, n.d.). Loneliness has even been linked with cognitive decline, with a large-scale research study finding that Alzheimer-like dementia symptoms were twice as likely in individuals who identified themselves to be lonely, with one hypothesis being that loneliness can undermine neural systems important for memory and cognition (Wilson et al., 2007). Indeed, a recent Public Health England report (2015) states that 'social isolation and loneliness is a major public health issue' (p.9, 2015).

Social support has been shown to be an important buffer to mental health and wellbeing in times of stress (e.g., Thoits, 1995). Community psychology writing refers to this in terms of social capital (e.g., Orford, 2008) and emphasises the way in which social networks provide positive outcomes for the group as a whole, activated through a sense of enhanced connectedness and shared values. However, those of us who need it most might be least likely to receive it. The Marmot review (2010) drew together a vast amount of rigorous research to evidence the impact of inequalities in social and economic determinants (power, money and resources) on health and social wellbeing. The report evidenced poorer health and wellbeing outcomes for those most deprived in society, with multiple causal factors. In addition social support was found to be least available amongst the most disadvantaged (Marmot, 2010). The report named sustainable and healthy communities as a key priority for wellbeing, stating that input needs to be provided at all levels of society, proportionate to the level of inequality, for overall change to be made. This was argued to be essential for greater parity of wellbeing, measured by how long we live for, and how healthily.

This is not to infer that individual factors do not play a role- they do. Christina Victor and colleagues (Victor, Scrambler & Bond, 2009) assert that loneliness and older age are not ubiquitous, and that social relationships in later life are rooted in the life history of each person. Cacioppo, Grippo, London, Goosens and Cacioppo (2015) outline three dimensions of loneliness: intimate (described to be a perceived absence of a significant other), relational (a perceived absence of friendships or quality relationships) and collective loneliness (the perceived absence of valued social identities and networks). It might be that the psychological models we use most often within our work as clinical psychologists can effect some changes in people's perceptions of loneliness particularly at an intimate or relational level, by enabling consideration of our attachment relationships or cognitive biases (e.g., Cacioppo, Grippo, London, Goosens & Cacioppo, 2015).

However, in cases where multifactorial formulations point to a range of wider social factors as core to the experience of our distress, at a level which might be similar to, but not restricted to, Cacioppo et al's (2015) definition of collective loneliness, it has been my experience that we can feel limited in how we actually intervene. Whilst the profession of clinical psychology has provided a platform from which to launch community psychology (Levine, Perkins & Perkins, 2005), it would appear that we often struggle to own this approach within our practice. As the authors argue, clinical psychologists typically enter the picture at a curative rather than preventative point in the story. We also tend to work within systems dominated by the medical model where we are moulded to intervene in a way which places the solution to the problem within the individual. In addition, we know that there are barriers to older people accessing mental health services in the first place, with 18% of over 64 year

olds estimated to have mental health problems, but, as an example, only 5.2% accessing Improving Access to Psychological Therapies services (figures cited in a Department of Health report for IAPT, 2013). To me, the logic of using approaches within the communities of which older people are already a part seems evident. Yet, for this to be truly meaningful, work must not just be located within the community, but be of a community psychology orientation, focused on empowering people to effect real change within their contexts.

It was exciting to see Hughes, Jones and Offord (2015) present a range of resources and organisations whose aim it is to support older people experiencing loneliness, within the previous edition of the FPOP newsletter. A few other community-centred projects which might be of interest and potentially call for our further involvement include timebanking (see www.timebanking.org), where reciprocity is encouraged by exchanging social credits, built up through time and resources given, for help needed. The key idea behind this model is of equity, whereby one hour of a person's time is valued the same as another's, regardless of the activity being done. Other community-based ideas include peer support and becoming 'health trainers' (Royal Society for Public Health, 2014) where skills and knowledge are shared on a voluntary basis within one's local community. Approaches to research also espouse the values we hold, potentially enabling real change at a societal level to result. Mac-UK, a London-based charity which promotes positive mental health in young people displaying antisocial behaviour or involved with gangs evolved following the founder's doctoral ethnographic research concerned with encouraging different intergenerational interactions between younger and older people, centred around the activity of digital photography (Alcock, Camic, Barker, Haridi & Raven, 2011).

Systematic reviews of the literature indicate the efficacy of community approaches (e.g., O'Mara-Eves et al., 2013), approaches which are endorsed by the National Institute for Clinical Excellence (NICE, 2008). What I hope this current article can contribute to is the conversation about how we allow community psychology to be embraced within our practice as clinical psychologists, thus enabling further connected up working between the NHS and third sector organisations. Indeed for this to be possible, it seems to me that one of our main challenges is in asserting the need for as great a focus on preventative approaches within mental health as the persuasive arguments seemingly being heard with regard to physical health (e.g., NHS, 2014).

Potentially there are changes we can all make, whether it be facilitating action research, encouraging the services in which we work to take on a stance which truly allows a reciprocal arrangement with users of services, where their strengths are seen as equal and as valuable a resource as those that we are providing, or in volunteering our own time within our communities. In a recent debate at Salomons with colleagues and trainees I was reminded of the importance of making what we believe a part of our personal as well as our professional lives. Change has to be a part of what we do now, with a core stance within community psychology being one of action, not just academic discussion (Thompson, 2007). The positions we hold- impacted by factors such as our education, age, and class- provide power that we need to share to prevent collusion with dominant practices that further inequality.

At the close of this piece I want to conclude that loneliness in older people *is* an important issue, one that is beginning to be recognised in recent initiatives including the World Health Organisation's Global Network of Age-friendly Cities (WHO, n.d.), and the Campaign to End Loneliness (n.d.).

However it also feels necessary to acknowledge findings which suggest that younger generations overestimate how lonely older people are, compared with figures when asking older people themselves, with levels of loneliness similar between the under 25s and over 65s (Victor & Yang, 2012). So, whilst loneliness might well be a problem for our older generations, it is also important to bear in mind that we might well be imagining a gloomier picture for others than is the reality. Why? Perhaps it is comforting to project our own vulnerabilities onto others, as though loneliness is solely the domain of the elderly. Once we start to acknowledge that the current population of 'older people' are not one group; that we are ageing every moment and we will, ourselves, with luck, inhabit the domain of old age one day, it might be easier to see the value of putting into action now those changes we would like to see for our future.

Alain de Botton, philosopher, author and presenter, suggested in his book 'Religion for atheists' a number of ways in which aspects seen to be fundamental to religion and ultimately valuable for community could continue to be embraced within secular societies. His suggestion of communal meals for strangers with a prompt to move beyond merely superficial levels of conversation would mean that:

"One would be privy to accounts… that would generate an impression of our collective insanity and endearing fragility. Our conversations would free us from our more distorted fantasies about others' lives, by revealing the extent to which, beyond our well-defended facades, most of us are going a little out of our minds- and so have reason to stretch out a hand to our equally tortured neighbours." (Alain de Botton, 2012, p.46)

Wouldn't it be nice to imagine that in a shared social setting such as the pub, restaurants with communal tables, the bus stop or supermarket queue, we might actually begin to *talk* to those around us, rather than having to steadfastly ignore that others exist? How much this stems from a British sense of decorum, or is an extension of the 08.10 behaviour, I'm not too sure. And so this article is a call from one lonely community-oriented psychologist to others within the field of older people- to begin the conversation.

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References

AgeUK (2010). *Loneliness and isolation evidence review*. Retrieved from
http://www.ageuk.org.uk/documents/en-gb/for-
professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true)

Alcock, C.L., Camic, P.M., Barker, C., Haridi, C., & Raven, R. (2011). Intergenerational practice in the
community: A focused ethnographic evaluation. *Journal of Community & Applied Social Psychology,
21,* 419-432.

Andersson, L. (1998). Loneliness research and interventions: A review of the literature. *Aging &
Mental Health, 2*, 264–274.

Barnes, A. (2007, January 21). The happiest man in the world? *The Independent.* Retrieved from
http://www.independent.co.uk/news/uk/this-britain/the-happiest-man-in-the-world-433063.html

Cacioppo, S., Grippo, A.J., London, S., Goosens, L., & Cacioppo, J.T. (2015). Loneliness: Clinical import
and interventions. *Perspectives on Psychological Science, 10*(2), 238-249

Campaign to End Loneliness (n.d.). Retrieved from http://www.campaigntoendloneliness.org/threat-
to-health/

Campaign to End Loneliness (2011). *Safeguarding the convoy.* Retrieved from
http://campaigntoendloneliness.org/wp-content/uploads/downloads/2011/07/safeguarding-the-
convey_-_a-call-to-action-from-the-campaign-to-end-loneliness.pdf

De Botton, A., (2012). *Religion for atheists.* London: Penguin Books.

Department of Health (2013). *How to make IAPT more accessible to older people: A compendium.*
Retrieved from http://www.iapt.nhs.uk/silo/files/op-compendium.pdf

Hughes, R., Jones, C. & Offord, R. (2015). Community approaches to loneliness in older people.
Faculty of the Psychology of Older People (FPOP) Newsletter, 129, 48-53.

Khaleeli, H. (2013, Jan 22). Britain's loneliness epidemic. *The Guardian.* Retrieved from
http://www.theguardian.com/society/2013/jan/22/the-loneliness-epidemic

Levine, M. Perkins, D.D. & Perkins, D.V. (2005). *Principles of community psychology: Perspectives and
applications.* Oxford: Oxford University Print.

Li, W., Hodgetts, D., & Sonn, C. (2014). Multiple Senses of Community among older Chinese Migrants
to New Zealand. *Journal of Community & Applied Social Psychology, 24*, 26–36.

Maitland, S. (2014). *How to be alone.* London: Macmillan

Marmot, M. (2010). *Fair society, healthy lives. The Marmot review: Strategic review of health
inequalities in England post-2010.* London: Marmot review.

Mental Health Foundation (2010). *The lonely society?* Retrieved from
http://www.mentalhealth.org.uk/content/assets/pdf/publications/the_lonely_society_report.pdf

National Health Service (2014). Five year forward view. Retrieved from
http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

National Institute for Health and Care Excellence (2008). Community engagement: NICE public health guidance 9. Retrieved from https://www.nice.org.uk/guidance/ph9

O'Connor, S. (2014, May 03). Over 1 million people in the UK feel lonely. *AgeUK.* Retrieved from http://www.ageuk.org.uk/latest-news/archive/1-million-older-people-feel-lonely/

O'Mara-Eves, A., Brunton, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F.,.. Thomas, J. (2013). Community engagement to reduce inequalities in health: A systematic review, meta-analysis and economic analysis. *Public Health Research, 1*(4).

Orford, J. (2008). *Community psychology: Challenges, controversies and emerging consensus.* Chichester: John Wiley and Sons Ltd.

Public Health England (2015). A guide to community-centred approaches for health and wellbeing. London: Crown Copyright.

Ricard, M. (2010). *How to let altruism be your guide*. Retrieved from www.youtube.com/watch?v=_p_GKCr8rq8

Royal Society for Public Health (2014). *Tackling health inequalities: The case for investment in the wider public health workforce.* London: Royal Society for Public Health.

Thoits, P. A. (1995). Stress, coping and social support processes: Where are we? What next? *Journal of Health and Social Behavior, extra issue,* 53-79.

Thompson, M. (2007). Exploring the trainees' view of a socio-political approach within UK clinical psychology. *Journal of Community & Applied Social Psychology, 17*, 67-83.

Victor, C., Scrambler, S., & Bond, J. (2009). *The social world of older people: Understanding loneliness and social isolation in later life.* Berkshire: Open University Press.

Victor, C.R., & Yang, K. (2012). The prevalence of loneliness among adults: A case study of the United Kingdom. *The Journal of Psychology, 146(1-2),* 85-104.

Wilson, R.S., Krueger, K.R., Arnold, S.E, Schneider, J.A., Kelly, J.F., Barnes, L.L. … Bennett, D.A. (2007). Loneliness and risk of Alzheimer Disease. *Archives of General Psychiatry, 64,* 234–40.

World Health Organisation (n.d.). WHO global network of age-friendly cities and communities. Retrieved from http://www.who.int/ageing/projects/age_friendly_cities_network/en/