

Placa & Oham, 2019

Volume 5 Issue 2, pp. 1024-1039

Date of Publication: 12th October 2019

DOI- <https://dx.doi.org/10.20319/pijss.2019.52.10241039>

This paper can be cited as: Placa, V. L., & Oham, C., (2019). Loneliness and Young People Experiencing Mental Health Difficulties: Evidence and Further Research. PEOPLE: International Journal of Social Sciences, 5(2), 1024-1039.

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LONELINESS AND YOUNG PEOPLE EXPERIENCING MENTAL HEALTH DIFFICULTIES: EVIDENCE AND FURTHER RESEARCH

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Abstract

This article reviews the current evidence base around loneliness; mental health, and young people, and the challenges identified in conducting research in this area. It then proceeds to consider the scope of further research and its impact upon policy and practice; in terms of inclusion of more enhanced theoretical frameworks; use of qualitative research and methodologies and impact of research upon policy and practice and enablement of more effective policies and interventions.

Keywords

Loneliness, Mental Health, Young People, Research, Policy

1. Introduction

Loneliness and young people's mental health and wellbeing have become increasingly central to United Kingdom (UK) public health and wellbeing policy as the relationship between loneliness and negative physical and mental outcomes becomes more apparent (Mulry, & Piersol, 2014; Qualter et al., 2015; Victor & Yang, 2018). There is increasing recognition that tackling loneliness is a preventative measure that ameliorates quality of life, reducing long-

term costs for health and social care (Ali, 2017). The Local Government Association (LGA) (2018) has argued that individuals and communities assume a significant part in ensuring that lonely and isolated individuals are identified and included. Strategic planning and delivery to resolve loneliness should occur at the local level and through accountable care systems (ACSs), sustainability and transformation partnerships (STPs) (LGA, 2018).

Recently, the UK government has launched a loneliness strategy around the determinants of loneliness. The former Prime Minister, Theresa May, confirmed all General Practitioners (GPs) can refer patients experiencing loneliness to community activities and voluntary services by 2023. Through social prescription, GPs will signpost patients to community workers for bespoke support (GOV.UK, 2018). The “Future in Mind” Report by the Department of Health (DH) and NHS England (2015) sets out the need to promote, protect and improve children and young people’s mental health and wellbeing. Strategies include: fighting stigma and enhancing attitudes to mental illness; bringing in more access and waiting time standards for services; setting up “one stop shop” community support services; and ensuring access for vulnerable children and young people. This paper seeks to review the current evidence base around loneliness; mental health and young people and the challenges to conducting research in this area. It then proceeds to consider the scope of further research and its impact upon policy and practice.

Whilst the article primarily focuses upon the UK, this is not to negate the fact that loneliness, mental health, and wellbeing, are also considered global public health issues, with other Governments and global organizations confronted by similar challenges (XinQi Dong, Simon, Gorbien, Percak, & Golden, 2007; Tao Liu, Wong, & Tsai, 2016; Cacioppo, & Cacioppo, 2018). Issues of loneliness and social isolation are highly cultural variables, but it might be that in the future, continued globalization and urbanization mean that developing countries will begin to experience similar public health and wellbeing challenges similar to the UK.

As loneliness and social isolation become increasingly global public health and wellbeing issues, Governments from Australia and Denmark to Japan, as well as the UK, are starting to develop policies and initiatives around it. For example, in the US, in 2017, the Senate Committee on Ageing met to discuss loneliness; and Mike Lee, a Republican senator from Utah, established the social capital project, researching the network of relationships in people’s lives, which can contribute to resolving issues around loneliness. Similarly, the World Health Organization (WHO) lists “social support networks” as a determinant of health (Wilkinson, &

Marmot, 2003). The article now moves to consider the current evidence base as regards loneliness; mental health and young people.

2. Social Isolation and Loneliness

Evidence was produced through a narrative review which uses diverse sources from which conclusions are generated into all-rounded interpretations, based on reviewers' models and definitional frameworks (Popay, & Mallinson, 2013). The authors generated detailed inclusion criteria to establish efficacious evidence in provision of sources on loneliness; mental health and young people. The primary inclusion criteria were that sources should originate from reliable evidence and that the sources identified dealt mostly with loneliness; mental health and young people (as much of the literature is biased towards older people and physical disabilities e.g. Illiffe et al., 2007). Relevant key search terms were devised to locate evidence ; for example, "mental health and loneliness" and/or "young people and loneliness". The search engines International Bibliography of the Social Sciences, SwetsWise and JSTOR were employed to identify sources.

A review of the literature selected indicates that it appears overall to mark a difference between "loneliness" and "isolation". Age UK (2015) perceives "isolation" as separation from social or familial contact, community involvement, or access to services, but "loneliness" is construed as an individual's personal, subjective feeling of not having such things. Furthermore, whilst social isolation is perceived as an objective circumstance; seen in terms of the quantity of social relationships – loneliness is a subjectively constructed phenomenon.

Living alone, for instance, due to being single, divorced, or widowed; lack of participation in social and community groups; fewer friends; and strained and upset relationships are often the main causes of loneliness, and often a risk factor for premature mortality (Illiffe, 2007; Holt-Lunstad, Smith, & Layton, 2010; Beckes, & Coan, 2011; Blachnio, Przepiorka, Boruch, & Balaker, 2016; Holt-Lunstad, 2017; Segrin, Nevaerz, Arroyo, & Harwood, 2018; Sharabi, Levi, & Margalit, 2018). Morrison and Smith (2018) identified, for example, absence of stable and close relationships, attachment, social integration and reassurance of worth as key causes of loneliness. Restricted face-to-face communication, the result of growing use of the Internet, and other information technologies, were also identified as prevalent (Bonetti, Campbell, & Gilmore, 2010; Ozdemir, Kuzucu, & Ak, 2014; Morrison, & Smith, 2018). Imrie (2018) perceived increasing urbanization and failing infrastructure as lessening opportunities for people to meet and develop relations, arguing for urban development that fostered inclusivity and opportunities for people to meet. Sagan (2018) has

argued that loneliness and isolation are the result of the increased dominance of neo-liberal thought and restructuring of relations between people in capitalist societies that create atomisation, lack of interaction, and therefore, higher rates of mental ill health throughout the population.

According to Age UK (2015) degrees of loneliness in the UK have stayed consistent over time, with around 10% of individuals over 65 experiencing chronic loneliness. (Victor, 2011). However, as the number of older people has augmented, the proportion of people experiencing loneliness often, or all of the time, has amplified – leaving more older people experiencing negative outcomes. In the UK, three quarters of GPs surveyed have reported that they are seeing significant amounts of patients with issues around loneliness, which is also connected to numerous health conditions including heart disease, strokes and Alzheimer’s disease. Around 200,000 older people in the UK report not having engaged in conversation with friends and/or relatives in over a month (GOV.UK, 2018).

Significantly, most of the evidence on social isolation and loneliness focuses upon older individuals only. This ignores the fact that children and young people, particularly with mental health issues, often experience isolation and loneliness, just as intensely as older people (The Guardian, 2014). Evidence suggests that there is a trend towards young people reporting greater incidences of feeling lonely and isolated. The Office for National Statistics (2018) found that with regard to young people between the ages of 16 and 24, 9.8% reported that they were “often” lonely (Office for National Statistics, 2018).

A survey of more than 55,000 people, organized by BBC Radio 4’s “All in the Mind” in collaboration with the Wellcome Trust, has enabled some new data as regards being lonely. The Loneliness Experiment, steered by Developmental Psychologist Professor Pamela Qualter, was the biggest survey so far conducted on loneliness; and disclosed that 16- to 24-year-olds experience loneliness more often and more intensely than other age groups (BBC, 2018). It ascertained that 40% of 16- to 24-year-olds reported feeling lonely “often or very often” while 29% of those aged 65 to 74 and 27% of people aged over 75 reported similar experiences. Evidence also suggests, for example, that causes of loneliness and isolation can be both personal and social. For example, bullying at school, fear of ostracism and changes in family structure and communities, have all been cited as significant causes (Mental Health Foundation, 2010). Victor and Yang (2018) ascertained that loneliness in young people increased the likelihood of poor physical health outcomes, too.

In considering solutions to loneliness, it is important to consider how the experience of mental health difficulties also affects experiences of loneliness, particularly in young people. Recent research confirms a strong link between perceived loneliness and increasing mental health difficulties for young people (Coan, Scharfer, & Davidson, 2006; Windle, Frances, & Coomber, 2011; Shahid, & Sumbul, 2017; Richardson, Elliott, & Roberts, 2017; Low, S. K., Tan, Kok, Nainee, & Viapude, 2018; Mishra, Deo Kodwani, Kumar, & Jain, 2018). Loneliness frequently co-occurs with depression, anxiety and self-harm, and lonely individuals are more likely to seek assistance from healthcare services for mental health difficulties, compared to individuals who do not identify as lonely. Lonely young adults are much more likely to experience mental health difficulties such as depression and anxiety, to have self-harmed or attempted suicide, and to have consulted their GP or a counsellor for mental health difficulties in the past year. Matthews et al. (2018) followed a longitudinal study of 2,232 individuals and found lonelier young adults were more likely to experience mental health difficulties, to participate in physical health risk behaviours, and to use negative strategies to alleviate stress. They displayed lower confidence as to the chances of gaining employment and were more likely not to have a job. Lonelier young adults were, as children, more likely to have experienced mental health difficulties, as well as bullying and social isolation.

However, strategies to reduce and mitigate loneliness in young people with mental health difficulties are not yet adequately understood, leaving a significant gap in knowledge about their experiences of loneliness and mental health difficulties and potential solutions. (Coan, & Sbarra, 2015; Matthews et al., 2018). Mann et al. (2017) looked at existing interventions to reduce loneliness in people with mental health difficulties, the evidence-base for different types of approaches, and the wider considerations involved in delivering interventions. The authors classified two main categories of interventions: The first constitute “direct” interventions, which specifically aim at reducing feelings of loneliness. These encompassed counselling approaches to reduce maladaptive patterns of thinking, training in social skills, support to access new opportunities for social contact, and involvement in community-based groups. For example, the Local Government Association (LGA) (2018) has also identified “Structural Enablers”, people or organizations, that encourage communities or individuals to engage with, and support each other; for example, implementing age-friendly, dementia-friendly and mental health-friendly communities; promoting volunteering and deploying peer and intergenerational support in communities.

The second category, “indirect” interventions, makes references to more broader determinants and efforts to ameliorate peoples’ wellbeing, which may, in turn, have a mitigating effect on loneliness. These could, for example, include endeavours to reduce inequality and lack of opportunity when designing interventions with a structural impact. Gateway services such as broad services like transport, technology, spatial planning and housing, which make it easier for communities to cooperate and coalesce, are examples (Local Government Association (LGA), 2018). These can assume the form of identifying options for affordable and accessible transport; age-friendly driving and parking; and focus upon social networks as a public health issue when considering major planning developments. The article will now proceed to focus upon the challenges of the current evidence base in relation to loneliness, mental health, and young people.

3. Challenges within the Current Evidence Base

There is a paucity of evidence in terms of consideration of young people, loneliness and mental health, and the current evidence base is in need of being broadened and enhanced. Conducting research in this area is characterized by various challenges, which either impede or reduce its findings and impact. For instance, Mann et al. (2017) have identified challenges to conducting research around tackling loneliness and mental health difficulties. Firstly, there is the social stigma often identified with loneliness and especially mental health. Secondly, loneliness, being a very subjective feeling, linked to intimacy and privacy, is often difficult to measure or assess, particularly through questionnaires and loneliness scales, for example, the UCLA Loneliness Scale and the de Jong Gierveld loneliness scale (both used broadly in mental health research). Thirdly, the fact that loneliness is conceptually contested and experienced differently, means it is unlikely that solutions are one size fits all types.

Whilst much of the literature on loneliness is from a psychological and/or clinical perspective, (e.g., Hawkey, & Cacioppo, 2010; Masi, Chen, Hawkey, & Cacioppo, 2010; Cacioppo, Capitanio & Cacioppo; Gerst-Emerson, & Jayawardhana, 2015), there is a gap in the research concerning loneliness as understood from a societal perspective and the wider determinants which often engender loneliness within individuals and policy and practice responses (Cacioppo, Cacioppo, & Boomsma, 2014; Age UK, 2015; Goossens et al., 2015; The Mental Health Foundation, 2017). While loneliness is often conceptualised as a psycho-social issue, often influenced by the bio-medical perspective, it also affects individuals’ and populations’ health and wellbeing, which have implications for wider health, economic, and social inequalities, poverty and inclusion of minority groups (Carter, Qualter & Dix, 2015;

Local Government Association (LGA), 2012; The Mental Health Foundation, 2017). Similarly, much of the current evidence lacks clear and concise theoretical frameworks to encompass existing empirical research; and which would provide for broader structural and societal explanations around loneliness, mental health, and young people.

Leigh-Hunt et al. (2017) conducted a systematic review of literature focused upon loneliness and social isolation and highlighted consistent evidence connecting social isolation and loneliness to negative cardiovascular and psychological health outcomes, suggesting over-emphasis upon the psychological and clinical elements. The role of social isolation and loneliness in other conditions and their socio-economic consequences was less clear. They also found that more evidence was required as regard to associations with cancer, health behaviours, and the impact of wider determinants such as experience of the life-course and the wider socio-economic consequences of loneliness.

Also, much of the evidence makes little effort to distinguish “health” from “wellbeing”, and both concepts are often used interchangeably. In public health studies, the concept of health is normally framed within bio-medical and positivist frameworks, with an emphasis upon health as a physiological aspect of illness and disease (La Placa, McNaught, & Knight, 2013). “Wellbeing”, however, often broadens such definitions to assume a holistic framework that proceeds beyond the bio-medical framework, embracing psychology; the self, and emotion, as well as broader determinants of wellbeing such as economies; housing and social inequalities. Whilst both definitions of health and wellbeing are contested, the competing definitional framework and contexts around them, used by researchers and policy makers, will assume more importance in framing research and policy around loneliness and mental health. This is particularly relevant in terms of providing solutions and assisting service users and lonely individuals. The article will now move to consider the scope and nature of further research on loneliness, mental health and young people.

4. Further Research on Loneliness, Mental Health and Young People

This section outlines what is required to proceed in terms of further research into loneliness, mental health, and young people, given the current constraints outlined in the evidence base above. Firstly, there is a need for researchers to use and develop existing social and psychological theoretical frameworks to provide for broader underpinnings to support empirical research. For example, the “Health Field Concept”, may be drawn upon to contextualize loneliness and mental health. This framework identifies four main domains that

affect health and wellbeing (Lalonde, 1974; Green, Tones, Cross, & Woodall, 2015). The first is human biology that includes all elements of mental and physical health, which are developed within the human body, as a result of the basic biological and organic make-up of the body. The second domain is that of the environment and the wider social structures (both physical, social and economic) which often go beyond the control of the individual. The third is lifestyle, which consists of the aggregation of decisions by people, which affect their health. The fourth comprises healthcare organizations and the quantity, quality, arrangement, nature and relations of individuals and resources in provision of health and wellbeing care.

The Health Field Concept also has ability to critically frame how individuals construct and negotiate their life-worlds and lived experience within the wider determinants that shape their responses, choices, opportunities and barriers which individuals confront in day-to-day activities and praxis (Green, & Labonte, 2008) enabling a critical public health approach. It would also provide an alternative to the wider psychological and clinical research into loneliness, which often perceives individuals in isolation of their wider circumstances (Centre for Policy on Ageing, 2014).

Researchers looking to frame loneliness and mental health within a wellbeing orientated context might also look to McNaught's (2011) definitional framework of wellbeing (McNaught, 2011). Wellbeing is depicted as a macro idea focusing upon objective and subjective evaluations of wellbeing. The framework stretches wellbeing to various domains beyond individual subjectivity to encompass the family, community and society. It reflects the conceptual complexity of wellbeing, and focuses upon its contingency upon numerous social, economic and environmental domains, that enable the resources and the contexts for wellbeing across society. Clearly, this offers a range of potential means of researching loneliness and mental health in young people and perspectives to develop policy and practice.

Secondly, more qualitative research is required to expand and enhance the current evidence base, given that much of the existing base is highly biased towards quantitative methods. Qualitative research and methodologies aim to generate rich and detailed data on people's experience of coping with and managing loneliness in young people (Kelly, 2013; Green, & Thorogood, 2014) and also enable the development of broader and more generic interventions targeted at a younger audience. Qualitative methods will enable an in-depth understanding of the research subject and provide detailed data to be used in future studies, using other theories and methodologies. Mann et al. (2017) have argued that more qualitative

research needs to be conducted in relation to loneliness and mental health, given the limited nature of current quantitative measures.

Qualitative research would explore the meanings imputed to loneliness and how it affects individuals in day-to-day activity; as well as the impact upon health and wellbeing and strategies to alleviate it. It would also enable researchers to focus upon, in greater depth, what younger people themselves would find appropriate to alleviate loneliness and suggest new strategies to mitigate the effects of loneliness to improve health and wellbeing. Qualitative research would assist to generate detailed narratives that can be constructed around why people act in certain ways, and their feelings about these actions (Savin-Baden, & Howell Major, 2013). They would also provide the basis for construction and development of policy and strategy.

Third, further research into loneliness, mental health and young people, should comprise the capacity to enable policy makers and healthcare practitioners to apply the results to improve and enhance current policies and strategies around loneliness and solutions to alleviating social isolation and loneliness. Research results should enable policy communities and healthcare professionals to develop key messages and preliminary interventions based around lifestyle and health-related behaviour change (Smith, Humphreys, Heslington, La Placa, McVey, & Macgregor, 2011; La Placa, McVey, MacGregor, Smith, & Scott, 2013). Social Enterprises, local authorities, voluntary organizations and Health and Wellbeing boards would find this useful in the development of Joint Strategic Needs Assessment (JSNA) for health and social care commissioners to plan services in the UK (Knight, & La Placa, 2013; Ife, 2016; Oham, & Macdonald, 2016). It is also hoped that any interventions developed as a result could be implemented and evaluated for their effectiveness and development in the future. For example, specific interventions could assume the form of a loneliness screening tool/tool kit and social media educational resources, using social innovation models (Durkin, & Oham, 2016), in relation to loneliness and mental health. It might also contribute to development of local tools to assist researchers and practitioners to measure the effectiveness of potential interventions.

Potential responses to loneliness in young people also need to draw upon the economic and social capital and resources of local communities and networks. For example, according to Leigh-Hunt et al. (2017), policy makers and health and local government commissioners should conceptualise social isolation and loneliness as relevant upstream factors that impact on

morbidity and mortality. Prevention strategies should therefore be promoted across the public and voluntary sectors, using asset-based approaches.

Further research should proceed beyond individualistic and psychological accounts and contribute to developing evidence based theoretical and empirical knowledge to develop future models, intervention materials, and best practice. It should also be geared to assisting local policy and practice in terms of knowledge concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment as well as community health. Further research should also aim to provide for an overall view of local health and healthcare needs to be integrated into wider local policy, as well as highlighting health inequalities and documenting service provision and unmet needs (Ife, 2016). The focus needs to shift to empowering people through challenging existing forms of inequalities.

Further research should also precipitate enhanced understanding of how young people with mental health difficulties experience social isolation and loneliness beyond the current psychological and clinical foundations of the current evidence base. It would aim to extend the potential to meet the needs of young people experiencing loneliness and isolation by addressing their health and wellbeing needs. It would also encourage exploratory development around interventions to alleviate loneliness in young people with mental health challenges and contribute to wider public health policy and practice.

5. Conclusion

This article has proceeded to review the current evidence base around loneliness, mental health, and young people, and the challenges identified in conducting research in this area. It then proceeded to consider the scope of further research and its impact upon policy and practice; in terms of inclusion of more enhanced theoretical frameworks; use of qualitative research and methodologies and impact of research upon policy and practice and enablement of more effective policies and interventions.

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