# Social Participation, Loneliness and Depression

6

Heather Burroughs and Ross Wilkie

## 6.1 Introduction

Retirement from paid employment and other changes in role can, for some older people, lead to a decline in social participation. A lack of social participation can cause loneliness, but the two states are not synonymous. Loneliness is emotional distress [1]; it has been described as a mismatch between the social relationships people desire and those that they actually have [2]. It can manifest in different forms – it can be a longing for the company of a particular person or it can be a generalised desire for a wider social circle. By widening the social circle and increasing social participation, there is some evidence that loneliness can be reduced [3].

Indeed, there is a body of research suggesting that participation in social activities is important in maintaining mental and physical well-being [4–7]. Numerous studies suggest that social participation can lead to an increase in physical exercise, social support and the sharing of health information [8–10]. In addition, social participation helps to maintain a sense of identity and can provide a sense of satisfaction and mastery [8].

## 6.2 Loneliness Is Linked to Depression

There are around 3.8 million people over the age of 65 living alone [11], and loneliness is common – it can be chronic or sporadic or manifest at particular times such as anniversaries or holidays. The prevalence of severe loneliness is up to 10 % [12].

H. Burroughs, BSocSci, MPhil, PhD (✉) • R. Wilkie, BSC, PhD
Research Institute for Primary Care and Health Sciences, Keele University, Keele, Staffordshire, UK
e-mail: h.burroughs@keele.ac.uk; r.wilkie@keele.ac.uk



C.A. Chew-Graham, M. Ray (eds.), *Mental Health and Older People: A Guide for Primary Care Practitioners*, DOI 10.1007/978-3-319-29492-6_6

Loneliness is thought to have negative consequences for humans because we are social beings and perceived isolation provokes feelings of being unsafe [13].

As a concept, loneliness can be divided into two categories – *social* loneliness, which is when one has a lack of social contacts, and *emotional* loneliness, when one is lacking a key emotional relationship [14]. Differentiating these two types of loneliness helps to explain why some people with a large number of social contacts or a non-satisfying quality of contacts consider themselves to be lonely, whereas others in a similar situation do not.

Loneliness is a normal part of human experience, but when it occurs for long periods or frequently and is felt very severely, then it becomes a cause for concern. Loneliness has been strongly associated with depression [15–17], and longitudinal work has reported loneliness to be an independent risk factor for future depression amongst older adults [18]. Cacioppo describes depressive symptomatology and loneliness as having a 'synergistic effect', mutually reinforcing one another to diminish well-being.

As well as common mental health problems such as depression, loneliness is predictive of more severe problems such as suicide in older age groups [19]. Further, loneliness has been found to be a precursor of dementia and cognitive decline [20], being a better predictor of such conditions than depression.

Cacioppo [12] argues that the chronically lonely become hypervigilant for signs of threat in the environment and over time cognitive biases colour perceptions so that the world is viewed in a more dangerous and negative light. The expectation of threat and negative interactions can become a self-fulfilling prophecy. In this way, the prospect of social interaction becomes a source of anxiety and is avoided.

Loneliness is linked not only to mental health problems – it predicts physical morbidity [21–23] increased health services utilisation [24] and increased mortality. It also slows recovery from illness [25], and its effects can be as detrimental as smoking [26].

## 6.3 Measuring Loneliness

There are existing tools that could be used to identify adults who are lonely and may benefit from interventions. The three-item loneliness scale (Table 6.1) [27] can be used through face-to-face and telephone interview in research and practice. The response options for all three items, 1 = hardly ever, 2 = some of the time and 3 = often, are summed with increasing scores indicating increasing loneliness. This correlates with the UCLA Loneliness Scale [28] which is used widely. To score, the Oftens = 3, the Sometimes = 2, the Rarelys = 1, and the Nevers = 0. In the United States, the ten-item version of the UCLA Loneliness Scale is offered by the American Association of Retired Persons to allow individuals to self-assess their level of loneliness and to seek intervention.

**Table 6.1** The three-item loneliness scale

| | Hardly ever | Some of the time | Often |
|---|---|---|---|
| 'How often do you feel you lack companionship?' | | | |
| 'How often do you feel left out?' | | | |
| 'How often do you feel isolated from others?' | | | |

From Hughes et al. [27] with permission

**Table 6.2** The De Jong Gierveld Scale

| |
|---|
| 1. There is always someone I can talk to about my day-to-day problems |
| 2. I miss having a really close friend |
| 3. I experience a general sense of emptiness |
| 4. There are plenty of people I can lean on when I have problems |
| 5. I miss the pleasure of the company of others |
| 6. I find my circle of friends and acquaintances too limited |
| 7. There are many people I can trust completely |
| 8. There are enough people I feel close to |
| 9. I miss having people around me |
| 10. I often feel rejected |
| 11. I can call on my friends whenever I need them |

From De Jong Gierveld and Van Tilburg [14] with permission

The De Jong Gierveld [14] measure is based on the cognitive theory of loneliness, and it emphasises the discrepancy between the social contact a person desires and what they are actually experiencing. This scale is probably the most commonly used in research and clinical practice (Table 6.2). The scale should be scored as follows: yes! (emphatic); yes; more or less; no; no! (emphatic).

## 6.4 Social Participation as an Intervention to Reduce Loneliness

In terms of quantifiable social participation as opposed to loneliness, half of older adults report that they are not taking part in at least one aspect of the social participatory activities they would like [29]. Reporting one in five reports that he/she is in contact with family, friends and neighbours less than once a week, and one in ten is in contact less than once a month [30]. Also, two fifths of older people (about 3.9 million) describe the television as their main company [31].

Public health authorities and local government have become increasingly concerned about the problem of loneliness and the detrimental effects amongst the growing population of older adults. Unfortunately there is no one simple solution – older people are not a homogenous group – and the self-reinforcing spiral of depression, ill-health and isolation makes a difficult problem that needs an individually tailored response.

In terms of evidence, the best work is from the United States [32] which suggests that there is a potential benefit from group social or educational activities in specific groups. Evidence from a systematic review [33] suggests that the most successful interventions for loneliness, measured by improvement in the domains of physical, mental and social health, tend to be group based, participatory and offering some activity [34–36]. Such community-based interventions have been shown to have additional benefits in terms of social inclusion and social cohesion [37–39].

With regard to older adults, creativity has been argued to be a critical element to ageing well [40], which is thought to enhance health and well-being as well as increase and sustain social interactions amongst older people [32, 41]. Indeed, aside from the social benefits, it has also been argued that creative activity is therapeutic in itself [42], and a number of community-based 'art for health' initiatives have been created in the United Kingdom [43]. However, it is clear that better designed studies, and in particular randomised controlled trials, are needed to improve the evidence base [28].

The problem with group-based participatory activities is that, although they may work to encourage social participation, reduce loneliness and alleviate depression for those who can be reached, there are several barriers inherent within them for this population: older people may have difficulties with transport; they may feel unwilling to walk into an established group alone, especially if they are depressed; they may need some one-to-one therapeutic input to even begin to think about increasing their social participation; and they may need some guidance to think about what type of group activity they might find meaningful.

In the light of these barriers, a reasonable way of approaching the Gordian knot of depression, anxiety, ill-health and loneliness might be individualised therapeutic input with an emphasis on behavioural activation followed by practical assistance to attend a meaningful group activity. Further high-quality research in this area would be welcomed.

## 6.5 Measuring Social Participation

In clinical practice, the assessment and monitoring of social participation may be useful to inform clinical decisions (e.g. by identifying low or restricted social participation) and to evaluate the effectiveness of interventions. Measurement of

social participation is in its infancy. There have been a number of reviews [44–47] that have highlighted instruments for use in research and to evaluate practice. Wilkie and colleagues in their review [46] highlighted instruments that have been designed to exclusively measure social participation in adult populations (and therefore provide a score specific for social participation), can be obtained easily, are free of charge and have some reported evidence of their ability to measure social participation to support their use (Table 6.1). None of these instruments as yet have been shown to have a clear advantage over the others. Selection of an instrument to measure social participation will depend on how the instrument measures social participation (e.g. frequency or as people would like) or the number of items, which will impact on responder burden and also on the detail of social participation that is measured. Each of the selected instruments in Table 6.1 is designed to measure participation in a different way; the Impact on Participation and Autonomy measures choice and control (i.e. the possibility to do the things the way you want) [48], the Keele Assessment of Participation measures performance in participation 'as and when you want', [28], Participation Measure for Post-Acute Care (PM-PAC) [49] measures limitation, Participation Objective, Participation Subjective (POPS) [50] measures objective (i.e. frequency) and subjective (i.e. satisfaction) participation, Rating of Perceived Participation measures the individual's perceived and desire to change [51] and the Participation Scale [52] measures participation compared to a 'peer norm'. All of the instruments measure participation in mobility, self-care, domestic life, interpersonal interaction and relationships, major life (e.g. work, education) and community and social life, except POPS which does not measure aspects of self-care. The instruments contain a varying number of items (range: 11–78); this is linked to the detail of participation measured (e.g. KAP contains the fewest items and measures participation broadly at domain level (i.e. measures participation in a number of activities in one item); POPS and ROPP contain the greatest number of items and provide greater detail by measuring participation in specific life situations).

At the moment, there are no instruments which have a proven ability to measure change in social participation, which is important for examining the impact of interventions and how participation may change over time. The health benefits gained from social participation will be through actual participation, and this may be the target for intervention studies. Currently there is a need to develop an instrument that measures actual participation in older adults that is responsive to change. This may require a better understanding of what social participation is in older adults which will facilitate development of the conceptual model for measurement, but it is crucial to identify links with loneliness. It is unknown whether loneliness may be linked more so with the quality of perceived participation (e.g. participating 'as and when they want') than with the amount of participation (Table 6.3).

**Table 6.3** Summary of the characteristics of examples of instruments designed to measure participation and social function

| Name of measure/scale | Purpose/content | Method of administration | Respondent burden (time to complete) | Administration burden | Interpretation of scores |
|---|---|---|---|---|---|
| Impact on Participation and Autonomy | 23 items. Measures choice and control of participation | Self-complete questionnaire | 30 min | Minimal | Higher score = greater perceived participation restriction |
| Keele Assessment of Participation | 11 items. Measures person-perceived performance in participation tasks | Self-complete questionnaire | 3 min. 98.2 % completion rate | Minimal | Range: 0–11, higher score = more restrictions |
| Participation Objective, Participation Subjective (POPS) | 78 items. Measures objective and subjective participation in 26 activities | Self-complete or interview | No information | Minimal | Range for subjective participation: −4 to 4. Range objective participation: −3 to 3. Higher scores = greater participation |
| Rating of Perceived Participation | 66 items. Measures perceived level, satisfaction and need for support to change the level of participation in 22 activities | Self-complete questionnaire | 15–30 min | Minimal | Range: 0–88, Higher score = greater participation restriction |
| The Participation Scale | 18 items. Compare an individual's participation to a 'peer norm' | Interview | 20 min | 20 min to administer | Range: 1–5, higher score = greater restriction |
| | | | | | Arbitrary severity categories provided |

## 6.6 Implications for Practice

Loneliness is a serious predicament that can have severely detrimental effects on mental and physical well-being to such an extent that it is increasingly being seen as a public health issue. The good news is that loneliness can be identified by using the correct tools, and there is evidence that interventions which facilitate meaningful social participation can be helpful.

## 6.7 Suggested Activities

Do you have a patient or client who seems lonely? How would you broach this sensitive topic? How do you normally assess this? Are there other things you could do to assess loneliness in your work?

How can you support a patient or client to increase their social participation? How do you find out what resources are available in your area? What barriers might there be to participation? Is there a way to overcome these barriers?

**Key Points**

- Up to 10 % of older people are thought to be severely lonely.
- Loneliness can be conceptualised as a mismatch between the social relationships people desire and those that they actually have.
- Loneliness increases the risk of depression and suicide in older people.
- Interventions to increase social participation may reduce loneliness and depression.
- A number of tools are available to measure loneliness and social participation.

## References

1. Weeks DJ. A review of loneliness concepts, with particular reference to old age. Int J Geriatr Psychiatry. 1994;9(5):345–55.
2. Peplau LA, Perlman D. Perspectives on loneliness. In: Peplau LA, Perlman D, editors. Loneliness: a sourcebook of current theory, research and therapy. New York: Wiley; 1982. p. 1–18.
3. Cattan M, et al. Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. Ageing Soc. 2005;25(01):41–67.
4. Glass TA, Mendes De Leon C, Marottoli RA, Berkman LF. Population based study of social and productive activities as predictors of survival among elderly Americans. BMJ. 1999; 319(7208):478–83.
5. Sirven N, Debrand T. Social participation and healthy ageing: an international comparison using SHARE data. Soc Sci Med. 2008;67(12):2017–26.

6. Chiao C, Weng L, Botticello A. Social participation reduces depressive symptoms among older adults: an 18-year longitudinal analysis in Taiwan. BMC Public Health. 2011;11:292.
7. Menec VH. The relation between everyday activities and successful aging: a 6-year longitudinal study. J Gerontol Ser B Psychol Sci Soc Sci. 2003;58(2):S74–82.
8. Berkman LF, Glass T, Brissette I, Seeman TE. From social integration to health: Durkheim in the new millennium. Soc Sci Med. 2000;51(6):843–57.
9. Thraen-Borowski KM, Trentham-Dietz A, Edwards DF, Koltyn KF, Colbert LH. Dose-response relationships between physical activity, social participation, and health-related quality of life in colorectal cancer survivors. J Cancer Surviv. 2013;7(3):369–78.
10. Levasseur M, Desrosiers J, Whiteneck G. Accomplishment level and satisfaction with social participation of older adults: association with quality of life and best correlates. Qual Life Res Int J Qual Life Asp Treat Care Rehab. 2010;19(5):665–75.
11. General Lifestyle Survey 2011, Table 3.3. ONS, 2013.
12. Victor CR, Bowling A. A longitudinal analysis of loneliness among older people in Great Britain. J Psychol. 2012;146(3):313–31.
13. Cacioppo JT, Hawkley LC. Perceived social isolation and cognition. Trends Cogn Sci. 2009;13:447–54.
14. De Jong Gierveld J, Van Tilburg T. The De Jong Gierveld short scales for emotional and social loneliness: tested on data from 7 countries in the UN generations and gender surveys. Eur J Ageing. 2010;7(2):121–30.
15. Brown GW, Harris T. Social origins of depression: a studyof psychological disorder in women. New York: Free Press; 1978.
16. Weeks DG, Michela JL, Peplau LA, Bragg ME. Relation between loneliness and depression: a structural equation analysis. J Pers Soc Psychol. 1980;39:1238–44.
17. Shaver PR, Brennan KA. Measures of depression and loneliness. In: Robinson JP, Shaver PR, Wrightsman LS, editors. Measures of personality and social psychological attitudes: measures of social psychological attitudes, vol. 1. San Diego: Academic; 1991. p. 195–289.
18. Cacioppo JT, et al. Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. Psychol Aging. 2006;21(1):140.
19. O'Connell H, et al. Recent developments: suicide in older people. BMJ Br Med J. 2004;329(7471):895.
20. Wilson RS, Krueger KR, Arnold SE, et al. Loneliness and risk of Alzheimer disease. Arch Gen Psychiatry. 2007;64:234–40.
21. Hawkley LC, et al. Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. Psychol Aging. 2010;25(1):132.
22. Burholt V, Scharf T. Poor health and loneliness in later life: the role of depressive symptoms, social resources, and rural environments. J Gerontol Ser B: Psychol Sci Soc Sci. gbt121. 2013;69(2):311–24.
23. Lyyra TM, Heikkinen RL. Perceived social support and mortality in older people. J Gerontol Ser B Psychol Sci Soc Sci. 2006;61(3):S147–52.
24. Luanaigh CÓ, Lawlor BA. Loneliness and the health of older people. Int J Geriatr Psychiatry. 2008;23(12):1213–21.
25. Marmot MG, et al. Fair society, healthy lives: strategic review of health inequalities in England post-2010. London: UCL; 2010.
26. Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. PLoS Med. 2010;7(7):e1000316.
27. Hughes ME, Waite LJ, Hawkley LC, Cacioppo JT. A short scale for measuring loneliness in large surveys results from two population-based studies. Res Aging. 2004;26(6):655–72.
28. Russell D, Peplau LA, Ferguson ML. Developing a measure of loneliness. J Pers Assess. 1978;42(3):290–4.
29. Wilkie R, Peat G, Thomas E, Hooper H, Croft PR. The Keele assessment of participation: a new instrument to measure participation restriction in population studies. Combined qualitative and quantitative examination of its psychometric properties. Qual Life Res. 2005;4(8):1889–99.
30. Victor CR, Scambler S, Bowling A, Bond J. The prevalence of and risk factors for, loneliness in later life: a survey of older people in Great Britain. Ageing Soc. 2005;25:357–75.

31. Age UK. Loneliness in later life evidence review. London: Age UK; 2014.
32. Frost H, Haw S, Frank J. Promoting health and wellbeing in later life. Interventions in primary care and community settings. Edinburgh: MRC Scottish Collaboration for Public Health Research and Policy; 2010.
33. Dickens AP, Richards SH, Greaves CJ, Campbell JL. Interventions targeting social isolation in older people: a systematic review. BMC Public Health. 2011;11:647.
34. Tennstedt S, Howland J, Lachman M, Peterson E, Kasten L, Jette A. A randomized controlled trial of a group intervention to reduce fear of falling and associated activity restriction in older adults. J Gerontol B Psychol Sci Soc Sci. 1998;53:384–92.
35. Ciechanowski P, Wagner E, Schmaling K, Schwartz S, Williams B, Diehr P, et al. Community-integrated home-based depression treatment in adults. A randomized controlled trial. JAMA. 2004;291:1569–77.
36. McAuley E, Blissmer B, Marquez DX, Jerome GJ, Kramer AF, Katula J. Social relations, physical activity, and well-being in older adults. Prev Med. 2000;31:608–17.
37. Greaves CJ, Farbus L. Effects of creative and social activity on the health and well-being of socially isolated older people: outcomes from a multi-method observational study. J R Soc Promot Health. 2006;126(3):134–42.
38. Staricoff RL. Arts in health: the value of evaluation. J R Soc Promot Health. 2006;126:116–20.
39. Johnson V, Stanley J. Capturing the contribution of community arts to health and well-being. Int J Ment Health Promot. 2007;9:28–35.
40. Flood M. Exploring the relationships between creativity, depression, and successful aging. Act Adapt Aging. 2006;31:55–71.
41. Wikstrom BM. Social interaction associated with visual art discussions: a controlled intervention study. Aging Ment Health. 2002;6(1):82–7.
42. Everitt A, Hamilton R. Arts, health and community. Durham: Centre for Arts and Humanities in Health and Medicine; 2003.
43. Angus J. A review of evaluation in community-based art for health activity in the UK. London: Health Development Agency; 2002.
44. Resnik L, Plow MA. Measuring participation as defined by the international classification of functioning, disability and health: an evaluation of existing measures. Arch Phys Med Rehabil. 2009;90(5):856–66.
45. Noonan VK, Kopec JA, Noreau L, Singer J, Dvorak MF. A review of participation instruments based on the international classification of functioning, disability and health. Disabil Rehabil. 2009;31(23):1883–901.
46. Magasi S, Post MW. A comparative review of contemporary participation measures' psychometric properties and content coverage. Arch Phys Med Rehabil. 2010;91(9 Suppl):S17–28.
47. Wilkie R, Jordan JL, Muller S, Nicholls E, Healey EL, Van der Windt DA. Measures of social function and participation in musculoskeletal populations: impact on Participation and Autonomy (IPA), Keele Assessment of Participation (KAP), Participation Measure for Post-Acute Care (PM-PAC), Participation Objective, Participation Subjective (POPS), Rating of Perceived Participation (ROPP), and The Participation Scale. Arthritis Care Res. 2011;63(S11):S325–36.
48. Cardol M, de Haan RJ, de Jong BA, van den Bos GA, de Groot IJ. Psychometric properties of the impact on participation and autonomy questionnaire. Arch Phys Med Rehabil. 2001;82(2):210–6.
49. Gandek B, Sinclair SJ, Jette AM, Ware Jr JE. Development and initial psychometric evaluation of the participation measure for post-acute care (PM-PAC). Am J Phys Med Rehabil. 2007;86(1):57–71.
50. Brown, et al. Participation objective, participation subjective: a measure of participation combining outsider and insider perspectives. J Head Trauma Rehabil. 2004;19:459–81.
51. Sandström M, Lundin-Olsson L. Development and evaluation of a new questionnaire for rating perceived participation. Clin Rehabil. 2007;21(9):833–45.
52. Brakel WH, Anderson AM, Mutatkar RK, Bakirtzief Z, Nicholls PG, Raju MS, Das-Pattanayak RK. The participation scale: measuring a key concept in public health. Disabil Rehabil. 2006;28:193–203.