

Is patients' loneliness a matter for general practice? A qualitative study

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Abstract

Background

Loneliness is linked to morbidity and mortality and use of social and health services resources. Therefore, general practitioners may have an important role to play. However, not much is known about how general practitioners handle loneliness in their patients, and not much is known about the GPs' attitudes and willingness to take on this task.

Objective

This study focuses on GPs awareness of patients' loneliness and their attitudes towards and perceptions of possibilities to actively address loneliness during consultations.

Methods

We performed semi-structured interviews with 13 Danish general practitioners from urban and rural areas. The interviews were transcribed for thematic analysis.

Results

The interviewees had slightly different definitions of loneliness, but these differences did not seem to affect their attitudes and behaviour regarding lonely patients. Some were hesitant to mention the word loneliness in the dialogue with the patient and to write it in the patient record. The interviewees all regarded social network and loneliness to be a natural part of an anamnesis when relevant, but they did not consider it obvious to investigate feelings of loneliness in patients as an isolated task of theirs. Reasons for this were that "just diagnosing loneliness" was of limited use – or might be contraindicated – because GPs themselves normally have no tools or options to alleviate this feeling. Knowledge of municipal and other support activities for lonely people that GPs can refer to or recommend was limited.

Conclusions

Patients' feelings of loneliness were rarely on the agenda during general practice consultations though general practitioners regarded patients' loneliness and social network as a critical factor in disease and recovery. The dominant feeling of the GPs was that they themselves cannot help the patient get rid of the feeling of loneliness; and the GPs called for updated information on relevant activities outside general practice in order to be able to guide, motivate, and refer lonely patients.

Keywords

Loneliness, general practice, Denmark

Introduction

Loneliness is often seen described as a risk factor and as related to health in a negative way. The research literature abundantly documents this. E.g. a meta-analytical review concludes that people with weak social relationships have a higher mortality than people with stronger social relationships, and that the influence of weak social relationships on the risk of death is comparable with well-established risk factors for deaths such as smoking and alcohol consumption and exceeds other risk factors such as physical inactivity and obesity [1]. A Dutch study found that after 10 years of follow-up elderly men who experienced feelings of loneliness at baseline had a significant higher death rate than others, independent of social isolation and medical and psychiatric conditions [2]. American longitudinal studies found that in persons over 60 years of age loneliness was a predictor of functional decline and death [3,4]. Loneliness is reported being associated with hypertension in later life in a Malaysian population [5] and in an American population [6]. Loneliness has been shown to be a factor related to frequency of consultations with the general practitioner [7].

Due to such associations, feelings of loneliness might be an important and obvious factor to address in general practice consultations, having in mind that family medicine according to a widely approved definition i.a. should have a comprehensive approach including promotion of health and well-being in its patients and preventing disease [8].

The purpose of this study was to explore Danish GPs' attitudes towards and perceptions of possibilities to actively – and successfully – address the issue of loneliness during consultations. The findings should identify issues in special need of quality improvement.

Methods and materials

Thirteen semi-structured interviews with GPs were conducted. In order to have a wide and varied field of GPs' observations and experience a maximum variation sampling of respondents was made [9]. We wanted female and male GPs to be represented in the sample, older and younger GPs, singlehanded and group practices, and practices from both urban and rural areas. Invitations to participate in an interview were sent to 14 GPs in Copenhagen and to 13 GPs on the island of Bornholm (representing all practices on the island).

Within the first week after sending the invitations we contacted the GPs by phone to make appointments for interviews. Fourteen of the invited GPs accepted an interview, and 13 were interviewed. The most prominent reason for not accepting the invitation was lack of time.

The described recruitment procedure lead to an interview sample with an age distribution ranging from under 40 to over 75 (median: 57 years); four of the GPs were in singlehanded practices and the rest were in group practices with two or more GPs; seven of the GPs practiced in rural areas and six in different districts of Copenhagen. Four of the interviewees were females.

The interview-guide focused on GPs' knowledge of loneliness in their patients; knowledge of the consequences of loneliness; general practice as a possible arena for addressing loneliness; the

collaboration between general practice, municipalities, and private organizations in handling loneliness; the GPs' wishes for future collaboration; etc.

The interviews lasted for 45-60 minutes and were conducted by TT. All interviews but one took place at the GPs' clinics, and the one took place in the GP's home. The interviewees were promised full anonymity. All interviews were audio recorded and transcribed for the thematic analysis [10] that focused on the themes from the interview guide and additional themes that came up during the interviews. Similarities and differences across the interviews were sought for. Through initial readings of the interviews an overview of the material was attained and interesting utterances, experiences, and attitudes were bunched into overriding categories (themes) which were then scrutinized and specified in a process where the re-reading of the interviews checked and qualified the first coding within each interview and across interviews. Additional re-readings of the interviews contributed to further systematization of themes and relationships between them.

Results

There were no noteworthy differences in experiences and attitudes between GPs from rural and urban areas, between sexes, practice organizations, or the age of the GP.

When we contacted the GPs by phone during the recruitment process some of them hesitated to participate in an interview because – as they reasoned – they had no lonely patients or at least did not know of any and thus believed they had nothing to offer to the data collection of the project. However, it turned out that between the making of the appointment for an interview and the very interview respondents had thought much about lonely patients and were able to describe several case stories from their patient populations.

Definition and scope of loneliness

There were among the interviewees slightly different definitions of loneliness, although it was a common feature that loneliness was regarded as a feeling not necessarily related to the size of the social network. All respondents found it important to mention that people may have a large social network and still feel lonely, and that even spouses can feel lonely. On the other hand, feeling lonely is not necessarily a bed fellow for people living alone.

'The feeling of loneliness lies in the loss of the purpose of the earthly existence, and the feeling that your existence will not be missed, if you pass away', was one of the definitions. Other definitions revolved around the discrepancy between what you want from social contacts and what you actually get. One GP put it like this:

In some way there must be some mismatch in their lives so that they feel lonely. In some way they must have bad relationships.... communication... call it what you like, with their surroundings that they don't become a part of. Thus they regard themselves being lonely. So I think it is a token of a personal issue, conflict, essential needs in the one feeling lonely.

Most of the respondents explicitly distinguished between loneliness as a transient (situational) and as a chronic condition. Older adults having lost a spouse may feel lonely for months or even for years, especially if the deceased was the one with the biggest ability to socialize. When loneliness is a concomitant to mental illness it was the impression of the interviewed GPs that it has a more chronic character.

Who are the lonely patients – and how many are they?

The GPs were asked to mention who are the typical lonely patients in their patient populations – and how many are there? It was their impression that loneliness is more frequent in young and older people than in the middle-aged. This was thought to be related to a social network not yet being built up in younger people, respectively being decimated in old people.

Young people having left their home towns and moved to another area where they do not know anybody will have a small social network in the beginning; and for those with a limited ability to socialize loneliness will often become part of their lives for some time. This was mentioned by a couple of GPs in Copenhagen. But according to the interviewees the loneliness feeling of youngsters is seldom permanent as most of them are able to take action and get friends after some time. However, some of them stick in the negative feeling; and this goes especially for those who have some kind of psychic frailties. E.g. one of the GPs stated:

The younger lonely people will typically beforehand be vulnerable for some reason or other.

Older people who lose a spouse or whose social network diminishes due to bereavement may become lonely:

When living as a pair is no longer possible due to bereavement they may not have anything else, and then they become lonely. So, yes, there might be an age-continuum with a growing degree of loneliness.

Several interviewees stated the opinion that loneliness in old age may be reinforced with diminishing mobility and hereby lessened ability to participate in sociable activities and events.

Other interviewees regarded loneliness to be a problem for people of all ages who have some kind of psychiatric problems that makes it difficult for them to socialize or to live a normal social life. The GPs mentioned anxiety, depression, alcohol abuse, and a chaotic life as concomitant variables sometimes being etiological and contributing factors, sometimes being negatively affected and enhanced by the loneliness. Some of the interviewees talked about a chicken and egg problem: What came first? The depression or the feeling of loneliness? The alcohol abuse or the loneliness? They left these questions unanswered, indicating that it might be both ways around and that a clear direction is not always obvious.

None of the interviewed GPs were able to tell how many of their patients feel lonely. Almost all of them reported having absolutely no idea, some had estimates between two and five percent. One GP told that to her impression the number of patients with loneliness problems was diminishing, while others perceived it to be growing. One doctor said that *'the real number is probably bigger than you should expect'*.

Several of the interviewed GPs told about moments of astonishment when they suddenly realized that a patient of theirs was deeply lonesome. Some of them afterwards checked the patient record to find out whether they should have known or should have had a suspicion.

Some interviewees had the impression that lonely people have a more frequent use of health care services than others. Contrary to this, other interviewees thought that people with serious loneliness problems almost never turn up in the clinic.

Loneliness as a topic during consultations

When loneliness might be an issue of importance for the handling of the patient's presented problem and for negotiating treatment regimens and rehabilitation plans, the GPs found it expedient to set the social network on the agenda. They would do so in order to find out whether some relatives of the patient or others could bring him/her to the specialist, collect the prescribed medicine, be encouraging and supportive with regard to rehabilitation activities and self-care etc. However, the interviewees did not consider it obvious to investigate feelings of loneliness in patients as an isolated task of theirs. Reasons given was that *'just diagnosing loneliness'* was of limited use – or might even be contraindicated – because GPs themselves think that normally they have no tools or options to alleviate this feeling. Therefore, none of the GPs in our study used screening-like procedures to identify loneliness in their patients, and few of them were ready or eager to scrutinize this *'because the existential loneliness problem is really difficult for us to solve'*. It was obvious from the interviews that especially chronic loneliness was a condition that the GPs were hesitant to engage in, whereas loneliness of a possibly transient character– for instance in connection with bereavement – was more often addressed.

Although there was a common understanding of loneliness being an etiological factor, a contributing reason for some visits to the general practitioners, and a negative factor for recovery, many of the interviewed GPs were hesitant to use the very word loneliness during a consultation (or even to write it in the patient record). There were different reason for this, the predominant one being fear of stigmatizing the patient and thus promoting further negative feelings of loneliness. The fear of stigmatizing seems to be emphasized by the fact that GPs found it very rare to hear patients using the word loneliness themselves, in the GPs' perception probably because they find it shameful to feel lonely.

The word lonely is used very, very seldom. Well, maybe... but that's in a different way, it's in connection with bereavement. (...) It is still tabooed in some way, for the doctor as well as for the patient.

One doctor pushed it to extremes:

People consider themselves as stigmatized if they tell that they feel lonesome. They would rather prefer being called depressive or lunatics or something else.

Instead of asking patients about loneliness, the interviewed GPs choose to ask whether the patients have someone to help them or someone with whom they can discuss the illness and the treatment.

The fact that none of the interviewed GPs had procedures to screen or otherwise routines to bring up the issue of loneliness was challenged by the interviewer by mentioning research findings estimating the health risk of loneliness as being almost equal to the risk of smoking, alcohol abuse, physical inactivity or obesity which all are issues that general practice more willingly pays attention to. The interviewees' reactions to this were mainly of the type: We are unable to change their social network or to eradicate their feelings of loneliness, and lonely patients themselves do not have the energy or ability to take adequate action. So why should we bring up the issue?

Most interviewees perceived the solution to feelings of loneliness as lying outside the consultation room, and therefore they were not that eager to focus on it without direct relevance for the clinical problem at hand.

Resources outside general practice

What the GPs can do with regard to patients' loneliness was described as informing the patients about local activities and private organizations, referring to municipal bodies or recommending community resources, and to encourage them to participate. But although some of the GPs mentioned that relevant private organizations now and then send leaflets to general practice informing about their programs and activities, the GPs' knowledge of current activities and resources targeted lonely people was described as rather limited. Some of them stated dissatisfaction with the level of information from the municipalities as well. One of the GPs in Copenhagen showed the interviewer a ring binder containing descriptions of municipal projects targeted at old and lonely people. It was the latest news. However, it was ten years old. And the GP did not trust in its information anymore. Likewise, most of the GPs did not find the online information from the municipalities of much use or relevance to the topic of loneliness. Some of them mentioned that if they want to find resources on the municipal's website for general practitioners, there is no entry point for loneliness as there is for COPD, diabetes, dementia etc.

Interviewees mentioned the municipals' so-called day centres for older people in need of support for daily functions and social interaction that they find it difficult to get elsewhere. But many of the interviewees told that several of their patients did not like to come there. Moreover, the interviewed GPs regarded the other clients there to be rather heavily burdened with somatic and psychic dysfunctions so that lonely older people would hardly prosper from social contacts with them.

The interviewees knew of private organizations like Red Cross and its voluntary visitors for elderly citizens that they sometimes recommended to lonely patients. But none of the interviewed GPs had taken contact to the organization on behalf of the patient during the consultation.

When it comes to serious and devastating loneliness a psychologist might be needed according to the interviewees. But in the Danish health care system '*loneliness is not reimbursed*' as one of them put it. This was mentioned as a problem especially as debilitating loneliness most often is found in individuals with limited economic resources. Therefore, some of the GPs were in such cases inclined to make a diagnosis that would generate reimbursement for consultations with a psychologist, e.g. depression.

What might make GPs more focused on loneliness?

The interviewees were asked what might stimulate general practice's involvement in patients' feelings of loneliness. Overall, the answers revealed the underlying attitude that although '*it is furiously relevant*' to take interest in feelings of loneliness it is an issue that might be better taken care of outside general practice, and that the GPs mostly were prone to examine the issue of loneliness and social network only in cases where it is directly relevant for the presented clinical problem. The arguments for this narrowed focus was lack of time, numerous other tasks to take care of in general practice, and loneliness often being too complicated an issue for a general practitioner to handle. However, the interviewees had suggestions for approaches that might fuel their interest and ability in handling loneliness.

Overall, the GPs expressed that they would be more inclined to focus on feelings of loneliness if there were adequate municipal and private resources to recommend or refer lonely patients to, and if they had comprehensive and updated information on what these resources can offer when and how. For instance, one of the GPs said:

Yeah, but loneliness as a topic in general practice is something that I've become aware of [as a response to participate in this project] that I've not before thought much about. I think that if you dive deeper into the issue it would have a bigger volume than you expect. And if we should do more about it, it also requires that we have something to offer to people, relevant offers. If this is not the case, I think we cheat them. Finding an illness or a condition and then being unable to take care of it afterwards isn't very fruitful. (...) If we cannot do anything about it, should we then uncover it? Should we then examine it? Does it help? Is it good? Have we done anything good?

Some of the interviewees thought that GPs might need additional continuous medical education (CME) on when, how, and in which kind of patients they should bring up the issue, and what they should do in case of a detected feeling of deep loneliness. Some more sceptical GPs regarded optional CME on loneliness as less urgent because they did not expect GPs to take an interest in it since they would regard loneliness to be very much in the periphery of what one could regard as a task for general practice.

Discussion

Before we designed the study and began data collection it was our expectation that the GPs do not regard it feasible to address loneliness in their patients as an isolated issue or as a matter of general prevention during consultation. Instead, we expected the social network to come up in consultations in relation to treatment and recovery issues, e.g. whether the patient has anyone to help picking up his/her medicine from the drug store, any relative to take care and look after or to share one's anxiety. The interviews confirmed these pre-conceptions.

One of the important reasons for the reluctance to bring up the issue of loneliness was the GPs' perceptions and experiences that they do not have adequate time, skills and tools to really help the patients get rid of the feeling of loneliness. This result is in accordance with other studies, e.g. van Ravesteijn et al.'s [11] and van der Zwet et al.'s [12] in Dutch general practice. They found that although GPs perceived it as relevant to recognize loneliness in patients, they were hesitant to bring up the topic. Most of them found it difficult to deal with loneliness due to lack of time or due to feeling powerless and not knowing how to deal with the problem. Further, like in our study, GPs questioned whether it was a GP's duty to tackle loneliness. The findings of the study by van der Zwet et al. [12] that GPs are more reluctant to address loneliness the more chronic it is, is also the overall impression from our study. Transient loneliness due to bereavement or other temporary personal crisis seemed more often verbalized by the GPs during consultations.

When GPs consider themselves lacking skills and possibilities during consultations to adequately support patients of theirs to combat feelings of loneliness, they might prosper from collaboration with agencies, professionals and lay outside general practice. However, the interviewees were mostly not well informed about such options. Some of them knew of private organizations that might be of some interest to lonely patients, some of them knew of municipal projects and activities targeted at mostly older lonely people. It seemed a problem for all the interviewees that they were not fully updated and had a limited knowledge of municipal and other community resources for lonely people. Therefore, they mostly felt unable to inform and adequately advise their lonely patients and to refer them relevantly; and this made them more reluctant during consultations to bring up the issue of loneliness.

The impression of the interviewed GPs that loneliness is more frequent in young and in older people than in the middle-aged people is in accordance with findings in a Danish survey study showing that 'often unwantedly alone' was a feeling most present in the age groups 16-24 years (7.4% of the respondents in this age group) and 75+ years (9.6%) [13].

There might be a large spectrum of different mechanisms that link feelings of loneliness and social isolation with physical and mental problems and consumption of health services [6,14]. However, this does not make it less important to address social isolation and loneliness in a generic way. Our study has given the impression that Danish general practitioners do not regard the combat of loneliness in their patients as a field of competence or a core service of theirs, but general practice can nevertheless play an important role in different ways: In raising the issue of feelings of

loneliness; in recommending or referring to e.g. public sociable activities and community resources; and in motivating patients to engage in these. Important prerequisites for this are a high level of alertness and clinical attention in the GPs towards loneliness as well as a continually updated knowledge and comprehensive information from the relevant activities and community resources to general practice.

Strengths and limitations of the study

Data saturation was reached after half of the interviews, and from then on no substantial new information or differing attitudes were obtained in the subsequent interviews. The maximum variation sampling of respondents in this study and the data saturation make the shared perceptions, experiences, and views seem valid for other general practitioners in Denmark. We have no reasons to believe that this sample would be very different from most other Danish general practitioners in these respects.

The study and its findings might have prospered from additional data on lonely patients' attitudes and wishes regarding loneliness-related interventions from their GPs; and barriers and options in the collaboration between general practice and municipal resources could have been elaborated upon by further data collection among these resources. Future studies should explore these issues in combination to elaborate on patient perceived needs, GP attitudes and behaviours and collaborative possibilities and resources under different contextual conditions.

Conclusion

This study indicates that GPs seem to have limited knowledge of their patients' feelings of loneliness; and loneliness and social network is an issue in a consultation primarily when the GP regards it as essential for the handling of the patient's presented problem. Certain patient types are perceived by the GPs to be more at risk of loneliness: younger and older people compared to middle aged, and patients of all ages with mental illness or psychic problems. Further, they differentiate between transient and chronic loneliness and are more reluctant to address the latter. GPs' perception that patients' feelings of loneliness is not their field of competence or core services and that the solution lies outside the consultation room requires that GPs should have updated information on relevant activities outside general practice in order to guide, motivate, and refer lonely patients.

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Authors' contributions

TT designed the study, collected the data, analysed and interpreted the data, and drafted the manuscript.

TDD participated in the interpretation of the data, and the drafting of the manuscript.

FBW participated in the design of the study, the interpretation of the data, and the drafting of the manuscript.

All authors read and approved the final manuscript.