General Practitioners' Views And Experiences Of Loneliness In Their Older Adult Patients

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CONTENTS

ABSTRACT

Background: Loneliness is associated with numerous detrimental effects on physical health, mental health, cognition, and lifestyle. Older adults are one of the groups at highest risk of loneliness, and indeed about 46% of older adults in England are lonely. Those experiencing loneliness visit their General Practitioner (GP) more frequently than those who are not, which has the capacity to put a strain on GPs and primary care waiting lists and costs. There is some literature on GPs' experiences of other social problems, but it is yet unknown how GPs in the UK perceive and work with loneliness in older adult patients.

Aims: To explore GPs' views and experiences of loneliness within their older adult patients.

Method: A qualitative approach was taken for this research and followed a social constructivist perspective. 19 GPs were recruited using researcher contacts, snowballing, and purposive sampling. Individual semi-structured interviews were conducted either in person or over the telephone. Data were transcribed and analysed using thematic analysis

Findings: Five over-arching themes and 14 corresponding sub-themes were presented. GPs' definitions of loneliness and its prevalence in our society is discussed. GPs held a medicalised and individualistic view regarding loneliness. They discussed their barriers to raising the topic, as well as the social stigma surrounding loneliness for both GP and patient. GPs felt powerless in their ability to fix the problem, and tended to use self-protection strategies. Further need for GP support and system improvements were discussed.

Conclusions: Study findings are discussed in the context of relevant theories and literature. Implications include greater emphasis on social problems like loneliness in

GP training, more practical and emotional support for qualified GPs, and a clearer more streamlined approach to managing loneliness presentations in primary care. Strengths and limitations of the study are discussed, and avenues for future research suggested.

Introduction Summary

This chapter aims to give an in-depth introduction to the present study. It will firstly introduce the concept of loneliness, and explore its physical, social, and psychological definitions, as well as consider relevant theories related to loneliness as a construct. Later life links with loneliness will be discussed, highlighting how loneliness affects older adults and outlining the importance of a focus on this particular age group. Loneliness will then be examined through the lens of current government policies and campaigns. The introduction will also report on the history of the GP (General Practitioner) and their evolving role in today's political and financial climate, whilst considering traditional medical theories versus evolving social theories within general practice. Finally, a systematic review on the current literature surrounding GPs' experiences of managing social problems will be conducted, and the findings used to outline a need and purpose of the present study.

Loneliness

Definitions of loneliness

There are numerous different definitions and meanings for the term "loneliness". The dictionary describes it simply as "being without company" or "sadness because one has no friends or company" (Merriam-Webster, 2017; Oxford English Dictionary, 2017). The emphasis of this definition is at a physical level, suggesting that it is merely the tangible absence of other beings that brings about feelings of loneliness. However, the literature on loneliness goes beyond this unidimensional explanation and discusses other definitions and ways in which people can experience loneliness.

Peplau & Perlman (1982) define loneliness as a state when a person's social network becomes deficient for their needs. They also suggest a psychological perspective for explaining loneliness in line with Bowlby's (1969) theory of attachment: that humans seek out proximity to other humans in order to have the best chance of survival, and this consequently manifests itself as a basic need for interaction and intimacy with others.

Other papers challenge the idea that loneliness is merely to do with not being around others, and suggest that it is possible to be surrounded by people and still feel lonely, as well as be completely alone but not feel lonely (Townsend & Tunstall, 1973; Wenger, Davies, Shatahmasebi, & Scott, 1996). De Jong Gierveld (1998) suggests that this discrepancy between different people is because it is the *quality* of people's relationships which is important in determining whether those relationships are enough to meet a person's needs, or not. Each person will have unique needs and thresholds for companionship, and de Jong Gierveld therefore argues that loneliness is created through each person's individual *perception* of their interactions and experiences with others. This would suggest that the same situation could be experienced differently by everyone.

De Jong Gierveld's argument ties in with philosophical arguments relating to ontology and epistemology (Guba & Lincoln, 1994). For example, a Positivist stance may argue that social isolation is experienced in the same way by everybody, and that the same social situation will cause the same outcome for everybody. On the other

side of the scale, a constructivist stance would argue that there is no one single reality and that everybody experiences social isolation differently, and that different situations are required for different people in order to feel lonely. Furthermore, Killeen (1998) makes the distinction between loneliness and social isolation. She states that while 'loneliness' tends to be used as a pejorative term, 'social isolation' can be perceived as either a good or a bad state, depending on a person's *choice* whether or not to be in that state. This argument is keeping in line with the social constructivist viewpoint, indicating that *choice* and *perception* of a state is key in understanding the feeling of loneliness.

Despite the argument that loneliness is a 'disease' and harmful to physical and psychological health (Tiwari, 2013), loneliness is not an officially diagnosable state, in the sense that it does not fall under a category within the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition, American Psychiatric Association, 2013). It is also not present in routine questionnaires within primary care (Meyer & Schuyler, 2011). It is argued that whilst it should remain outside of the realm of the DSM-5, that it nevertheless needs to be taken seriously as a public health problem (Pies, 2010).

Loneliness theories

The difference between a physical state of social isolation and the subjective construct of a feeling of loneliness has been delineated above. Here, evolutionary, attachment, and social theories will be considered in relation to what loneliness is, and how and why it is experienced.

Biological and evolutionary perspectives

It has been suggested that social interactions and 'social pain' are processed by the same set of neurones that process physical pain (MacDonald & Leary, 2005), thereby instigating a genuine biological response. Evolutionary theory purports that this very real 'pain' resulting from social isolation drives us to seek proximity to others, and this therefore encourages and maintains group obedience and increased co-operation, thereby helping our species to survive (Cacioppo, Cacioppo, & Boomsma, 2014). Loneliness is therefore considered to be genetically heritable as it serves a positive evolutionary purpose (Goossens, van Roekel, Verhagen, Cacioppo, Cacioppo, Maes, & Boomsma, 2015), and feelings of loneliness are expected to drive interaction and closeness to others. Conversely, papers published by the same researchers, Cacioppo and colleagues (Cacioppo, Hawkley, Ernst, Burleson, Berntson, Nouriani, & Spiegel, 2006; Cacioppo & Hawkley, 2009) put forward an evolutionary perspective on how loneliness can also work differently to result in changes in behaviour which maintain feelings of loneliness. They suggest that feeling lonely can cause people to feel unsafe and therefore more hypervigilant for additional social threats in their environment, seeing the world as a negative place, as well as expecting and remembering more negative social interactions than they normally would. Subsequently, through believing that others in the world around them are threatening or negative, the lonely person will perceive as this being out of their control and will distance themselves from other people. This will thereby cause them to feel even more lonely, confirming feelings of being unsafe, and feeding into the self-fulfilling cycle. It is evident that at the moment these are merely theories which speculate on the evolutionary role in loneliness.

It is not entirely clear how the two seemingly disparate ideas by the same authors marry up: that is, the idea that loneliness encourages people to seek more companionship from others; and the idea that loneliness causes people to distance themselves from others. There appears to be potential for consideration of systemic and attachment theories within these ideas, and perhaps a limitation of the above evolutionary theories is the absence of consideration of others' roles within an individual's loneliness.

Attachment theory

Attachment theory was originally borne from Bowlby's (1969) observations of infant attachment to their caregivers, and the behaviours they used to avoid separation, such as crying and holding onto their caregiver. Ainsworth and Bell (1970) built on this by testing out the theory in vivo in the form of the "Strange Situation Test". From this joint work, attachment theory was developed and is now widely used to understand how someone relates to the world and others around them, depending on their attachment style created during infancy. In the 1980's and 1990's, attachment theory was developed further into thinking about adult attachment styles, resulting from infant experiences (e.g. Hazan & Shaver, 1990).

There are considered to be four main attachment styles in adults. Adults who are securely attached will have had their needs met fairly consistently as an infant. As a result, they are able to form close emotional bonds with others, but are not overly preoccupied about not being accepted. They are independent and self-sufficient, but at the same time do not have problems with asking for help or asking to get their

needs met. An adult with an anxious-preoccupied style tends to seek proximity and intimacy from others, and are often dependent on others for approval and to reduce their anxiety about their relationship. A dismissive-avoidant attachment style is characterised by a desire for independence and not being reliant on close emotional bonds with others. Adults who have experienced severe trauma in childhood may develop a fearful-avoidant attachment style, in which they desire close emotional intimacy, but have difficulty trusting others and so do not allow themselves to become emotionally close to others.

Early literature posits that humans are born with a requirement for intimacy from others which remains throughout life, and that loneliness may be caused by unmet social needs (Peplau & Perlman, 1982). Following on from this idea, literature has encapsulated the idea that attachment theory may be one angle from which the existence of loneliness can be viewed (Erozkan, 2011; Mikulincer & Shaver, 2013). Erozkan (2011) found a relationship between fearful, preoccupied, and dismissing attachment styles and increased feelings of loneliness, while there was no relationship between a secure attachment style and feelings of loneliness. This suggests that being insecurely attached from a young age and finding it more difficult to relate to others and express needs effectively may lead to higher likelihood of loneliness in adult life.

However, there are some criticisms of attachment theory which would argue against the above. For example, Harris (1998) suggests that it is not always the caregiver who is the main influence on a child, but rather their peers and the environment in which the child grows up in. Furthermore, it has been postulated that infants may not only form attachment styles with their primary caregiver, but also with other people

around them, potentially creating several different attachment styles (Field, 1996). If this is the case, then it is difficult to consider a significant link between different attachment styles and greater risk of loneliness.

Social theories

Theorists have been concerned with the link between the changing shape of society and the rise in loneliness that is being observed. It is postulated that several changes have happened in recent decades to alter how we interact with each other and view the world. For example, post-industrialisation may have had consequences on the nuclear family model, traditionalism, and the shift from a collectivist society to a more individualistic society (Gillies, 2003). A move towards distraditionalism, more rights for women, and greater capitalist opportunities has also seen a rise in divorce, childlessness, and people living alone (e.g. Gillies, 2003; Snell, 2016). Furthermore, a capitalist framework combined with this increased independence of individuals has given rise to a more individualistic society, and has moved away from the collectivist ideas of yore where people frequently turned to their families, neighbours, and priests for guidance and support. This may be used as an argument for the rise in loneliness within our society. However, Lykes and Kemmelmeier (2013) refute this idea, demonstrating that people in collectivist societies showed greater levels of loneliness. They note that individualistic societies value autonomy and making their own choices, while collectivist societies find social ties and bonds more important. Therefore, it may be that if a person within an individualistic society finds themselves unable to have their own autonomy or make their own choices with regards to the levels of interaction they have with others (e.g. when older people's health declines, or they suffer bereavement of loved ones), they may feel lonely. Similarly, if a person

within a collectivist society lacks the social bonds which they value, they will also feel lonely as a direct result of this.

Social reinforcement theory postulates that different behaviours can arise from social interactions depending on the reward or punishment nature of those interactions. Peplau and Perlman (1982) argue that social reinforcement may be one angle from which the existence of loneliness can be viewed, and that in fact, it is the absence of social interaction reinforcement which causes loneliness. An example is given of a person who talks intimately with a friend and finds this interaction rewarding; this pleasant sensation will encourage the person to do this again, reinforcing the behaviour. Conversely, if a person does not engage much with others and therefore lacks this reinforcement, they will be less likely to seek out social interactions in the future – thereby leading to potential loneliness. Presumably, the same might also be true of someone who does initially engage with others but has largely negative experiences ("punishment" function), thereby discouraging them from future interactions.

Social reinforcement can also play a role within the stigma that comes with feelings of loneliness. Due to the stigma associated with being lonely, this may prevent lonely people from talking about it with others or telling a wide network of people about it. This may mean that loneliness becomes a lesser-discussed issue, people are not asked about it as much (e.g. by friends, family, healthcare professionals), and this gives the message that it is something shameful that should remain hidden. This systemic maintenance loop may be at play with many 'socially undesirable" issues (such as mental health), reinforcing the stigma and maintaining the problem.

It is estimated that 68% of adults in the UK experience loneliness either sometimes, always, or often (RT, 2015), and has been commonly cited that loneliness can be as detrimental to health as smoking 15 cigarettes per day (Holt-Lunstad, Smith, & Layton, 2010). It is thought that there are antecedents and precipitating factors which can play a role in determining why some people are more likely to feel lonely than others. De Jong Gierveld (1998) states that people's personality traits and social skills play a role in their propensity to feel lonely. Health is another factor which can play a role (de Jong Gierveld & van Tilburg, 1995), as those with chronic conditions may not have the time or ability to interact with others as much as they would like.

Geographical limitations may be a precursor to loneliness, depending on whether a person lives in a rural or urban environment, and if this mirrors their needs (Fischer, 1973; Scott, 1979). Cultural and social norms can be a strong factor in determining whether people feel lonely or not. For example, if a society deems that having a certain number of relationships as optimal, then those who have a number of relationships under this quota may be more at risk of feeling lonely in comparison to others (Jylha & Jokela, 1990). Moreover, it is argued that simply situational attributes, such as age, can be a factor for increased likelihood for loneliness, for reasons such as decreasing social networks and greater difficulty with forming new ones as people get older (Morgan, 1988; Holme, Ericsson, & Winblad, 1994). It is important to note that the above factors might make a person more likely to be socially isolated, which is not the same as feeling lonely, as previously discussed. However, social isolation may be a precursor to loneliness for some people if their

social interactions are not sufficient for their needs, and therefore the above factors may indirectly cause some people to be lonely.

Negative consequences of loneliness

Loneliness has been shown to be associated with numerous negative outcomes. In older adults, loneliness has been linked to functional decline and death (Perissinotto, Cenzer, & Covinsky, 2012), higher mortality (Luo & Waite, 2014), and admittance to hospitals or nursing homes (Mor-Barak & Miller, 1991). Physical consequences include higher blood pressure (Hawkley, Masi, Berry, & Cacioppo, 2006), association with heart disease (Thurston & Kubzansky, 2009), increased speed of physiological ageing (Hawkley & Cacioppo, 2007), as well as poor sleep and a worse immune system response (Luanaigh & Lawlor, 2008).

In terms of the effects of loneliness on mental health, research suggests that older lonely people may be at higher risk of depression (Luanaigh & Lawlor, 2008), decreased self-esteem, and increased anxiety and anger (Cacioppo, Hawkley, Ernst, Burleson, Berntson, Nouriani, & Spiegel, 2006). Moreover, loneliness is linked to greater likelihood of suicide in later life (O'Connell, Chin, Cunningham, & Lawlor, 2004).

Loneliness has been associated with negative cognitive effects, such as a greater risk of developing dementia (Holwerda, Deeg, Beekman, Tilburg, Stek, Jonker, & Schoevers, 2014) and Alzheimer's disease (Wilson, Krueger, Arnold, Schneider, Kelly, Barnes, Tang, & Bennett, 2007). Loneliness is also linked with negative effects on lifestyle. For example, it is associated with decreased physical activity (Newall,

Chipperfield, Bailis, & Stewart, 2013), higher medication use (Cohen, Perlstein, Chapline, Kelly, Firth, & Simmens, 2006), and lonely older adults have a higher likelihood of becoming an 'at risk' user of alcohol (Immonen, Valvanne, & Pitkala, 2011). On the other hand, good social networks and quality interactions with others can act as a buffer against illness, and can also aid faster recovery from illness when it does occur (Marmot, 2010).

It is important to note that the above studies differ in their consistency of measuring purely loneliness and reporting on this. For example, some of the studies appear to be measuring largely just social isolation (which may lead to loneliness, but equally may not); some of them measure loneliness through the use of one question which asks about both social isolation and loneliness; and others do indeed focus purely on the feeling of loneliness. However, while it is evident that social isolation and loneliness are very much tied up together in loneliness research, it is important to note that feeling lonely and/or socially isolated was linked to serious implications for health, psychological wellbeing, and lifestyle in the above literature. It is therefore crucial to recognise and address loneliness (and social isolation where it is causing loneliness) in order to prevent some of the above consequences.

Loneliness and later life

Following on from the above point arguing that older age can be a determinant for greater risk of loneliness, this section will focus on the links between loneliness and later life, and why this thesis is focusing specifically on older adults.

Research suggests that loneliness is most prevalent in younger generations and older generations; specifically those aged under 25 and those aged over 65 (Victor & Yang, 2012). It is argued that the increasing loneliness in young people may be a side-effect of increased social media use, and subsequent perceived number of relationships compared to how many relationships a person believes they should have (Davey, 2016). Loneliness in older adults is more commonly acknowledged in society, as reasons for loneliness in older age remain constant throughout history and technological change. For example, retirement can cause a huge life change and need for adjustment, not just with everyday routines, but with socialising and interacting with others daily (Which Elderly Care, 2016). 'Which Elderly Care' also lists other factors linked to older age which can contribute to the development of loneliness, such as death of friends and spouses, deteriorating physical health which can restrict the ability to leave the house and socialise, and financial issues which may limit travel. As previously discussed, it is important to keep in mind the difference between the physical state of being socially isolated and the feeling of loneliness. The factors above may make older people more likely to be socially isolated, which for some people may then lead to feelings of loneliness, however social isolation may not necessarily lead to loneliness for everybody.

It is currently estimated that 46% of older adults in England report feelings of loneliness (Dahlberg & McKee, 2014), and this is expected to rise with the growing number of older people (Gill & Taylor, 2012). 49% of older people aged 75 and over live by themselves (Office for National Statistics, 2010), and 17% do not have regular once-a-week contact with others (AgeUK, 2014), which may make them feel socially isolated, and for some people extend to feelings of loneliness.

Whilst young people who are feeling lonely may have forms of support networks which are available to them such as school, college or older family members, this is not the case for older people. It appears that personality traits are the main predictor of loneliness in young people, whilst for older adults it is a mixture of circumstances that come with later life, such as bereavements and health problems (de Jong Gierveld, 1998; Victor, Scambler, Bowling, & Bond, 2005). Essentially, loneliness in older adults seems to be more permanent and less likely to change than it does for younger people. Loneliness in older adults is therefore an important and pertinent issue, and is the age group which this thesis will focus on. Furthermore, other age groups may have different needs and challenges to consider, therefore focusing on just one age group will add specificity and focus to the research question.

Current Campaigns and Policy Guidelines

Campaigns against loneliness

There are a number of current campaigns running aimed at raising awareness and helping to reduce loneliness within communities. For example, the Campaign to End Loneliness serves to raise awareness amongst clinicians, commissioners, and policy makers through evidence-based research. They publicise their videos on social media sites, such as Facebook, and most recently have released a video showing the effects on a young man who spends a week entirely alone without any form of communication with the outside world, raising awareness of this message to younger adults.

The Co-Operative and the British Red Cross (BRC) have recently joined forces to raise money in order to help tackle the issue of loneliness in the UK (Loneliness Campaign, 2007). They use the raised collection to set up new BRC services in May and June 2017 in multiple locations across the UK. The aim of these services is to help people re-integrate into their communities and address any problems they might have with doing so. Furthermore, they state that they have collected more funds than they had originally anticipated, and are as a result looking to fund further ways to support lonely people in connecting with others around them.

Policy guidelines for loneliness

Due to the negative health and social consequences of loneliness, there has been great discussion about its impact on National Health Service (NHS) services. Loneliness is associated with greater use of services, especially for residential care and social care (AgeUK, 2014). The impact of loneliness on NHS services such as hospitals and Accident & Emergency (A&E) has been documented by a doctor writing for the Guardian, stating that the NHS economy could become "crippled" by the rise of loneliness experienced by older adults (The Guardian, 2016). An article on the NHS England website argues that the physical and mental effects of social isolation and loneliness, twinned with high sickness and death rates in older adults, means that the arising healthcare costs from this will ultimately have to be managed by front-line NHS services, such as A&E and GPs (NHS England, 2015). It estimates the annual cost of this could be approximately a billion pounds, if not more, making the argument that loneliness in older adults must be tackled for the sake of the NHS economy.

Addressing loneliness is therefore evidently becoming more of a government priority and its importance is highlighted in the updated Adult Social Care Outcomes Framework for 2013/2014 (Department of Health, 2012). Public Health England (2015) provides a framework for reducing social isolation amongst all ages and life stages, and the Local Government Association (2012) recommends action at different levels, including across local authorities, the community, and amongst individuals.

Under the Labour government at the time, 2007 saw a jointly signed agreement by the NHS, government officials such as the Secretary of State for Health and the Secretary of State for Work and Pensions, as well as a variety of social care organisations (HM Government, 2007). This stipulated prioritising the reduction of loneliness in order for people to remain independent and living in their own homes for as long as possible. In practical terms, the government is piloting new local services for older adults, to include more face-to-face, telephone, post, and electronic interactions (Department for Work and Pensions, 2015). In 2010, the government declared plans for investing £1 million in social isolation and loneliness in older adults (Department for Work and Pensions, 2015), to achieve the above aim of older adults remaining independent and active within their communities for as long as possible. The current Conservative Prime Minister, Teresa May, has continued the work on loneliness as started by the late MP Jo Cox (Jo Cox Loneliness commission) and appointed a minister for loneliness, Tracey Crouch (BBC News, 2018). Her new role will include interacting with charities, organisations, and businesses in order to inform government strategy. The current government has also announced plans for greater emphasis on tackling loneliness, which will include establishing a strategy across the government for combating loneliness, growing the evidence-base on loneliness

management, and setting up funds to support charities and organisations (Government Press Release, 2018).

It has been emphasised that loneliness reduction should be done through prevention rather than cure, which may require a re-design of the current system so that people have access to interventions before it becomes a 'crisis' (Department of Health, 2006). This idea was built on a year later (Department of Health, 2007), purporting the idea of primary care practices using NHS resources in a flexible way which is in tune with their patients, and in this way providing prevention for loneliness rather than cure. The idea of GPs and primary care practices being involved in loneliness recognition and prevention will be explored in the following section.

GPs and Primary Care

Following on from the previous section, it is evident that loneliness prevention is a government priority, and there is a plan to include frontline primary care staff as part of this undertaking. This section will discuss the role of NHS GPs in the UK, and their role in the management of loneliness in older adult patients.

History of the GP role

The traditional definition of a GP is that of a medic at the frontline who sees patients with illnesses, sometimes of an unknown cause, and refers onto specialty medicine depending on the need (World Organisation of Family Doctors, 2011). Since the set-up of the NHS in 1948, specialist care and hospitals for patients have been accessed through general practice (The King's Fund, 2011). At the time, rigorous standards for practice did not exist and GPs worked separately without support from other

healthcare professionals or regulatory bodies. Conditions improved in the 1960's, when GPs were given practice size limitations, increased pay, and more staff to work alongside them within general practices. GPs were first granted a professional body in 1972, and this helped to regulate quality amongst general practice in the coming years. The 1990's saw the GP role begin to evolve, as GPs started to take more of a role in commissioning and integrating within the wider NHS (The King's Fund, 2011).

In April 2013, the NHS saw a huge reorganisation of its current structure. Previous to this, funding decisions were made by Primary Care Trusts (PCTs), and generally comprised of health managers. The government suggested that as GPs see patients regularly on the frontline, they are better connected to the direct needs of their patients in their specific localities. Therefore, in April 2013, PCTs were abolished and Clinical Commissioning Groups (CCGs) were established instead. Within this model, all GPs belonged to a CCG and these groups made decisions on which services should be funded within their areas (NHS England, 2013). Through this momentous change, the GP role changed significantly and GPs were given ultimate say on service funding, propelling them to the core of current services and the health care system. This means that in today's world, not only are GPs regularly seeing patients as the first port of call for accessing healthcare, but they also hold responsibilities for understanding the need for their localities and commissioning the services which are most needed.

The medical model and medicalisation

GPs are traditionally trained to manage physical health problems and treat them using medication or referral to specialist services. However, primary care is seeing an ever-increasing rise in 'social problems' such as mental health conditions and issues like loneliness (The King's Fund, 2016). This increase perhaps reflects a greater awareness and acceptance of issues such as mental health problems and non-physical lifestyle issues, as well as a decrease in stigma, leading to greater numbers of patients seeking help for these problems within primary care.

The medical model, traditionally taught in medical schools, is a Western idea postulating that all symptoms can be diagnosed and treated (Shah & Mountain, 2007). However, due to GPs encountering an increase in social problem presentations in primary care, they are having to work more holistically and carry out more social prescribing rather than rely purely on the medical model. One potential result of this is medicalisation of social problems. Medicalisation refers to placing a label on a problem and treating it using medical ideas (Maturo, 2012). This can be harmful if the problem is given a medical label in order to categorise patients who are 'difficult' or 'untreatable' (MIND, 1997). Pilgrim (2001) offers the example of personality disorder, which he argues is not a stable diagnosis and that it has been given a label in order to medicalise symptoms which are difficult to explain.

The rise of medicalisation has received a lot of criticism in the literature. While the medical model is upheld as a central tenet of Western healthcare and holds much influential power in our society, critics argue that conversely it can be detrimental to people's wellbeing through potential iatrogenic effects and by removing a sense of personal and communal autonomy over people's health (Illich, 1975). This relates to

the current topic of loneliness in the sense that within government policies loneliness is being spoken about as a medical condition which requires preventative treatment by the NHS and GPs, thereby medicalising and offering medical solutions to what is inherently a social problem, and ought to be dealt with as such. Illich's (1975) point above extends to this, purporting that perhaps medicalisation is taking away autonomy from the individual and their community in being able to help themselves manage and prevent loneliness, a social issue.

Research suggests that GPs are in conflict between whether a social issue like depression is something that can be medically diagnosed (i.e. caused by a chemical imbalance), or whether it is simply a natural reaction to life stresses (Thomas-MacLean & Stoppard, 2004). If it is not considered a "medical" issue then it cannot be treated in a traditionally medical way, and GPs may as a result feel redundant and incapable of helping. It is clear that there is a disconnect between the traditional medical model of doctor training and the holistic way in which GPs are practising in order to address the social problems which they are increasingly encountering. This is demonstrated in McPherson, Byng, and Oxley's (2014) paper, in which a patient tells a GP that she has nobody and is always on her own, suggesting volition to talk about this subject, however the GP responds with statements about blood pressure and increasing her medication. This evident disconnect in the way GPs believe they should address a problem and the inability of the medical model to effectively manage social problems may leave GPs feeling powerless and incapable of 'fixing' the problem in the way they are trained to do. This discrepancy needs further consideration, for the benefit of both the GPs' quality of working life, and for their patients' resultant care.

Despite being trained in a wider culture of the medical model, GPs-in-training follow a curriculum that goes beyond just learning medical knowledge, and extends to teaching a wider set of skills necessary for the GP role. For example, GPs are trained in personable skills which are crucial when working with others, such as communication skills, working with patients' families and carers, working within a team and showing leadership, as well as applying an ethical approach to their work and promoting and valuing equality and diversity (Royal College of General Practitioners (RCGP), 2015). The RCGP also states that GPs are taught how to work holistically, integrating patients' psychological, cultural, and socioeconomic circumstances with their physical presentation. It also stipulates that GPs are required to practise preventative medicine, and encourage patients to manage their own health and wellbeing. There is also emphasis on GPs learning more about themselves through the use of reflective practice, continuing with their professional development alongside their work, and being aware of their strengths and limitations as s GP. However, it is not clear how much time is devoted to the above areas within GP training, and whether different courses prioritise holistic teaching more over others. This may potentially lead to different GPs having different views regarding the importance of holistic and reflective practice, and these differences being apparent in disparate working styles across GPs in the UK.

GPs are also encouraged to make use of Balint groups, which are a resource for GPs to discuss difficult patient cases, with the focus on the emotions experienced by the patient and GP, rather than clinical content. They were first set up by psychoanalyst

Michael Balint in the 1950's and provided a place where GPs could reflect on their work and develop their listening skills (Salinsky, 2009). Nowadays the groups resemble a reflective group, where one GP presents a patient who they may be finding difficult to work with emotionally, and the group responds by discussing the case amongst themselves whilst the presenter listens. This provides GPs with a similar format to reflective teams in systemic therapy, or to reflective sessions in Clinical Psychology training, suggesting that they are then equipped with these reflective skills which they can use in their role as a qualified GP. However, it is again unclear how compulsory it is to attend these groups regularly, and how much GPs engage with them.

Working with loneliness in primary care

Working with social problems rather than traditional medical problems can influence GPs' workload, and also their feelings about their patient and themselves. For example, a cross-sectional study showed that working with psychological issues was more time-demanding for GPs and required more time spent diagnosing the problem (Zantinge, Verhaak, Kerssens, & Bensing, 2005). The study also states that working with mental health issues causes GPs to feel as though they do not have the sufficient amount of time to be able to help those patients. Shah and Harris's (1997) study suggests that GPs do not feel as confident in their diagnostic and identification skills when working with social problems.

Loneliness is one such social problem which arises in primary care, either directly or indirectly, and one which this thesis is focusing on. Research shows that people experiencing loneliness have been found to have higher frequency of consultations

with a GP (Ellaway, Wood, & MacIntyre, 1999). This may be due to the stigma surrounding loneliness causing people to not want to own up to having this problem (de Jong, 1998), but at the same time wanting a form of social contact. Given that GPs are the first port of call when accessing any type of healthcare (The King's Fund, 2011), and that patients tend to report high levels of trust in their GP (Tarrant, Stokes, & Baker, 2003), GP consultations may be a prime opportunity for such people experiencing loneliness to access a level of social contact by presenting with a physical complaint instead, whether they are consciously aware of this process or not.

The above studies show negative effects for GPs when working with social problems, such as a higher workload, feelings of time insufficiency, and a lack of confidence. It is crucial that these issues are considered and addressed, as in the long-term they may cause other negative effects in GPs, such as frustration, increased work stress, and an avoidance of working with arising social issues. The negative physical, psychological, and lifestyle effects of loneliness in the patient population has been discussed earlier in this chapter, and they suggest that these continued effects may result in increased use of NHS services. This therefore puts additional pressures on NHS consultation times, budgets, and service resources. In conjunction with the Department of Health's (2006) message that loneliness should be prevented rather than cured, it is crucial that the underlying issue of loneliness is identified and addressed as early as possible, in order to avoid the potential negative effects on patients, GPs, and the wider NHS system.

Social identity theory

A theory which is relevant to GPs' management of loneliness is that of social identity theory (Tajfel & Turner, 1979). Tajfel and Turner suggested that the different groups we belong to (e.g. gender, nationality, football team) form our sense of identity. This identity can be strengthened when identifying and acting in accordance with in-groups, and also by differentiating ourselves from out-groups. The same can also be claimed of professional groups, and it can be argued that somebody's identity may be formed by the type of job that they do. For example, GPs may categorise themselves into groups of "medical professional" or "doctor" or "GP", identify with the characteristics of other GPs that they know, and distance themselves from characteristics of out-group professionals, such as psychologists. This idea suggests that GPs may therefore take on broad characteristics that come with being a professional GP, such as being somebody who "fixes" problems quickly and efficiently, and somebody feels confident and competent in their work, as well as being stoic in the face of difficulty. Therefore, when these characteristics come under attack through working with social problems (discussed above), GPs may suffer an attack on their personal identity. It is important to consider the impact of greater presentation of social problems in primary care on GPs in this way, in order to understand personal barriers and concerns about addressing social problems, and how this can be best resolved.

Review of the Literature

INTRODUCTION

Recent medical literature has focused on the rise of social issues (e.g. loneliness, housing, finances) within general practice and medicine in general, and debated whether this is a role for medics at all (Krishnamoorthi, 2010; Kaplan test prep,

2016). Qualitative reviews have been conducted to ascertain GPs' experiences and management of their work with psychosocial and mental health issues, for example depression (McPherson & Armstrong, 2012). Studies of GP management of depression in fact also raise the topic of social issues (McPherson & Armstrong, 2009), suggesting some overlap between mental health problems and social problems within GP management. However, there is a lack of qualitative research on GP's views and experiences of specifically social issues in terms of non-medical problems, such as loneliness, housing, and relational concerns. Therefore, this systematic review aims to review the body of qualitative literature exploring GPs' experiences and management of a range of social problems that they encounter in their consultations.

METHODS

Inclusion and exclusion criteria

Participants

Studies were included if they utilised solely fully-qualified GPs in their research. Studies which used medical students, GP trainees, or other healthcare professionals either alone or in conjunction with GPs were excluded. This maintained a homogenous level of study participants, and ensured that the participants could draw on their experiences of working with their own caseload within primary care. Consideration was given to the different labels for GPs in studies from other countries (e.g. 'primary care physician'), and studies were included if the label was deemed to be equal to the GP role in the UK. Studies which included patients as participants, or which looked at the interaction between patients and their GP were excluded, due to the focus of the research question being GPs' personal experiences. Studies examining GPs' views and experiences of working with adult populations were

included, while those which asked about adolescent populations were excluded. This was because the relationship dynamics with adolescents who attend with parents or carers might be different, and this was therefore excluded to retain homogeneity within the GPs' patient populations.

Condition

Studies examining GPs' experiences of working with social problems (e.g. loneliness, benefits, housing, finances, relational issues) were included, while studies asking about medical problems and mental health issues were excluded.

Outcomes

Studies examining GPs' views, experiences, management, and constructions of 'social problems' were included, while those which reported social problems in a different context were excluded (e.g. reports on current provisions for GPs when working with 'social issues').

Study type

Qualitative studies, and mixed-method studies with a qualitative component, were included in this review, while quantitative studies were excluded. This ensured that the study was examining qualitative aspects such as views and experiences, in line with the review aims, rather than 'measuring' the phenomenon with other methods. Only peer-reviewed research articles were included in this review. Other formats such as abstracts and opinion articles were excluded as these would not have been able to

be compared to other studies in the review, and data would not have been able to be synthesised in an appropriate way. Articles which were not available in the English language were excluded due to inability to translate articles for this thesis.

Search methods

Search strategy

An electronic search of the following databases was conducted on 21/12/2017: CINAHL, MedLine, PsychINFO, and PsychARTICLES. These databases were chosen as they include psychological and medical literature, and qualitative research. No limiters were used in the search. The search terms used are shown in Table 1.

Table 1: Search terms

Search no.	Search term	Results
1	"lonel*" OR "social* isolat*" OR "solitary" OR "social problem*" OR "housing" OR "welfare" OR "financ*" (Abstract)	333,643
2	"GP*" OR "general practitioner*" OR "famil* doctor*" OR "famil* practitioner*" OR "primary care" OR "physician*" (Title)	252,965

3	"manag*" OR "negotiat*" OR "construct*" OR "address*" OR confront* OR "experienc*" OR "cope*" OR "view*" (Abstract)	2,746,507
4	"qualitative" OR "interview*" OR "focus group*" (Abstract	946,552
5	#1 *AND* #2 *AND* #3*AND* #4	437

Selection of studies

437 articles were found after using the above databases in an electronic search. Titles and abstracts of these articles were then reviewed against the eligibility criteria, and those which were eligible or difficult to determine then moved to full-text review. Alongside electronic searching, backwards and forwards citation tracking was utilised to identify any studies which may have been missed. This involved scanning reference lists of relevant articles, and searching for citations of relevant articles. One new eligible article was identified through this means and passed onto full-text review. In total, the full texts of 11 studies were reviewed and the same eligibility criteria applied. Of these, six articles satisfied the eligibility criteria, and were therefore used in this review. The process has been outlined using a PRISMA diagram (Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G. & The PRISMA Group, 2009; see Figure 1).

Figure 1: PRISMA diagram showing article selection process

Studies identified through database searching (n = **437**)	Studies identified through citation searching (n = **1**)

Total number of articles identified (n = **438**)

Studies excluded at title/abstract screen (n = **427**)

Duplicates (n=155)

Not GP management of an issue (n=131)

Not social problem (n=91)

Inclusion of other professionals or patients (n=23)

Not peer-reviewed research, e.g. Books, reviews, protocols (n=21)

Quantitative design (n=6)

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                    │
                    │
                    ▼
┌──────────────────────────────┐        ┌──────────────────────────────┐
│  Full-text articles assessed │        │  Studies excluded at full-text│
│         for eligibility      │───────▶│       screen (n = **5**)      │
│          (n = **11**)        │        │                              │
└──────────────────────────────┘        │  Inclusion of other          │
                    │                    │  professionals or            │
                    │                    │  patients (n=3)              │
                    ▼                    │                              │
┌──────────────────────────────┐        │  Not social problem (n=1)    │
│   Final number of studies    │        │                              │
│     included in review       │        │  Not in English (n=1)        │
│         (n = **6**)          │        └──────────────────────────────┘
└──────────────────────────────┘
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Quality appraisal

The importance of critically appraising research studies has been much discussed, and it is argued that the inclusion of poor quality studies can skew results and lead to unrealistic claims in the literature (Mhaskar, Emmanuel, Mishra, Patel, Naik & Kumar, 2009). However, there are numerous quality appraisal tools to choose from, for different types of study design, and there does not appear to be any one 'gold standard' (Katrak, Bialocerkowski, Massy-Westropp, Kumar & Grimmer, 2004).

For this study, the Critical Appraisal Skills Programme (CASP; 2017) qualitative research tool was used to appraise the quality of the 15 included studies. The CASP tool is useful in the sense that it covers 10 key bases of study quality and is thorough

in its questioning. However, it is limited in its binary nature, and it can be difficult to determine whether a study meets the criteria by simply classifying it as either 'yes' or 'no'. This can also make it difficult to judge some of the more dubious criteria: for example, articles satisfy some of the CASP tool "hints" but not others, rendering it challenging to determine whether the study has adequately met that particular criterion. It would have been more useful to rate the individual aspects of quality on a scale, as this would have portrayed a more realistic picture of the quality of articles.

No major issues were identified with any of the studies, and all studies had a clear statement of aims, appropriate methodology, design, recruitment strategy, data collection, ethical considerations, as well as clear statement of findings. However, none of the articles addressed the researcher-participant relationship and how this may affect the study. This may have been omitted due to the limited number of words allowed in publications. The rigour of data analysis remained unclear in one of the studies. However, in general all studies were appropriately designed and carried out (see Table 2).

Table 2: Critical appraisal of studies using the CASP tool

	Clear statement of aims?	Qualitative methodology appropriate?	Research design appropriate?	Recruitment strategy appropriate?	Data collection appropriate?	Researcher-participant relationship considered?	Ethical issues considered?	Data analysis rigorous?	Clear statement of findings?	Value of research?
Jego et al. (2016)	Y	Y	Y	Y	Y	N	Y	Y	Y	Discussion of implications
McCall-Hosenfeld et al. (2014)	Y	Y	Y	Y	Y	N	Y	Y	Y	Discussion of implications, and areas for future research

Swartling et al. (2008)	Y	Y	Y	Y	Y	N	Y	Y	Y	Discussion of implications and area for future research
Taft et al. (2004)	Y	Y	Y	Y	Y	N	Y	Y	Y	Discussion of contribution and implications
van Ravesteijn et al. (2008)	Y	Y	Y	Y	Y	N	Y	U	Y	Discussion of implications
van der Zwet et al. (2009)	Y	Y	Y	Y	Y	N	Y	N	Y	Discussion of implications and areas for future research

Data synthesis

Data from this review were synthesised using Thomas and Harden's (2008) thematic synthesis method. This involves following three steps: coding of the text; identifying themes at a 'descriptive' level; and identifying themes at an 'analytical' or interpretative level. Key themes emerging from the included studies will be examined, and similarities and differences discussed.

FINDINGS

The six included papers have been summarised in Table 3. Six over-arching themes were identified from the papers reviewed; some with sub-themes within. These are presented below, and similarities and differences between studies discussed.

Table 3: Study characteristics of included papers

Study	Country	GP Sample size	Issue being explored	Data collection method	Method of analysis	Main findings
Jego et al. (2016)	France	19	Homelessness	Interviews	Content analysis	Importance of follow-up; working together with other professionals such as social workers; barriers to working with homeless patients.
McCall-Hosenfeld et al. (2014)	USA	19	Partner violence/ domestic abuse	Interviews	Content analysis	Barriers to working with partner violence: time constraints in consultations, limited training in topic, limited resources for referral, potential impact on relationship between patient and GP. GPs associate certain symptoms with partner violence; interventions should address the discomfort of addressing partner violence within both patients and GPs.

Swartling et al. (2008)	Sweden	19	Sickness certification	Interviews	Content analysis	Barriers identified within and outside of the healthcare system. GP competence and judgement, general views and attitudes towards sickness certification, and organisational issues were all barriers encountered by GPs working with sick-listing.
Taft et al. (2004)	Australia	28	Partner violence/ domestic abuse	Interviews	Grounded theory	Barriers to working with partner violence: stress, GP gender, time constraints, lack of supervision/support, and lack of awareness of organisations to refer to.
van Ravesteijn et al. (2008)	Netherlands	20	Loneliness	Interviews	Grounded theory	Topic of loneliness is breached by patients and GPs in an indirect way; mixed reactions from patients when asked about loneliness; powerlessness to help; time constraints; optimism in being able to improve patients' loneliness.
van der Zwet et al. (2009)	Netherlands	20	Loneliness	Interviews	Grounded theory	Lack of referral options for lonely patients. GPs felt emotions such as powerlessness, frustration, and pity when working with loneliness.

Barriers to Addressing the Social Issue

The studies talked about various barriers for both the GPs in raising and addressing social issues, and also barriers for the patients themselves in bringing up the problems with their GPs. The majority of the studies cited lack of time and demands of the job as a barrier to addressing social issues which may typically take up longer consultation time (McCall-Hosenfeld, Weisman, Perry, Hillemeier, & Chuang, 2014; Swartling, Alexanderson, & Wahlstrom, 2008; Taft, Broome, Legge, 2004; van Ravesteijn, Lucassen, & van den Akker, 2008; van der Zwet, Koelewijn-van Loon, & van den Akker, 2009). Studies were also in agreement with the idea that a lack of referral options or access to resources discouraged GPs from broaching social issues, as they would then not have anywhere to refer the patient (McCall-Hosenfeld et al., 2014; Swartling et al., 2008; Taft et al., 2004; van Ravesteijn et al., 2008; van der Zwet et al., 2009).

Other barriers which prevented GPs from addressing social issues with their patients were poor patient compliance to treatments/interventions (Taft et al., 2004; van der Zwet et al., 2009), GPs' own discomfort with talking about the topic (McCall-Hosenfeld et al., 2014; Taft et al., 2004), worries about resultant patient dependency on the GP (van Ravesteijn et al., 2008; van der Zwet et al., 2009), and feelings of powerlessness around not being able to 'fix' the problem (Taft et al., 2004; van Ravesteijn et al., 2008). Taft and colleagues (2004) also raised the issue of gender and that being a female doctor can be beneficial when dealing with relational problems such as domestic violence; being a male GP in these circumstances therefore may pose as a barrier.

GPs also spoke about barriers from their patients' points of view. Van der Zwet et al. (2009) reported that patients felt ashamed to bring up the issue of loneliness with their GP. Stigma was cited as a barrier for patients, who may not wish to admit to their problem or raise it with their GP (McCall-Hosenfeld et al., 2014; Swartling et al., 2008).

Facilitators to Addressing the Social Issue

GPs discussed the factors which encouraged them and their patients to raise and talk about social issues. Studies reported that GPs find working with social issues interesting and rewarding (van Ravesteijn et al., 2008; van der Zwet et al., 2009). They also felt this work provided them with a challenge, feelings of accomplishment, and better relationships with their patients (Jego, Grassineau, Balique, Loundou, Sambuc, Daguzan, Gentile, & Gentile, 2016).

Care Management of Social Issues

The studies offered GPs' views on how social issues should be treated and managed in primary care. Jego and colleagues (2016) found that GPs believe that GPs play a key role in management and prevention of homelessness, and that this should continue to be managed by GPs. However, it is noted that care management can be complicated if patients have co-morbid issues (Jego et al., 2016) such as anxiety, depression, or sleep problems (Taft et al., 2004). It is emphasised that GPs' practice must be flexible and adaptable to working with social issues, and that follow-up is vital in building trust and providing the best care (Jego et al., 2016). McCall-Hosenfeld et al., (2014) suggest that interventions within the community are imperative in treatment as well.

GP as Human

Despite the GP role often being seen as medical and pragmatic, the studies showed GPs sharing a side of themselves not often seen by patients. The 'human' side of GPs was shown in the studies, with GPs feeling emotions such as pity and annoyance (van der Zwet et al., 2009), sadness, and frustration when patients do not comply or help themselves (Taft et al., 2004). GPs also expressed feelings of powerlessness and demoralisation at being able to 'fix' patients' problems (Taft et al., 2004; van van Ravesteijn et al., 2008; van der Zwet et al., 2009), and even stated that working with loneliness caused them to reflect on their own current and future situations (van der Zwet et al., 2009).

However, some GPs protected themselves from these arising feelings by keeping their emotions separate from their clinical work and creating barriers between themselves and potential emotions that may be evoked from working with social problems (van der Zwet et al., 2009). They may avoid discussing the problem by asking about it in an indirect way, or not acknowledging the issue even if it is suspected (Taft et al., 2004; van Ravesteijn et al., 2008).

GP Skills

The studies explored the various different skills that GPs consciously or unconsciously utilise within their work with patients, and in particular skills which help them to manage arising social issues. GPs felt that patients sometimes needed somebody to listen to them and that they occasionally found themselves acting as a type of counsellor (Taft et al., 2004). The studies also showed that GPs utilise their

skills to provide empathy (Jego et al., 2016; Taft et al., 2004), as well as validation and reassurance about their patients' problems (McCall-Hosenfeld et al., 2014).

System Improvements

The papers discussed GPs' views on how the current system for social problems within primary care could be improved. GPs thought that there should be greater involvement and communication between themselves and other professionals involved in the patients' care, for example social workers (Jego et al., 2016; Swartling et al., 2008). GPs reported that they felt they needed more knowledge and training in managing certain social domains within primary care (Jego et al., 2016; Taft et al., 2004), as well as more support through supervision (Taft et al., 2004).

Some GPs felt that they were doing most of the work with regards to patient improvement, and that the culture needs to shift so that patients are taking more responsibility over their own life changes (Taft et al., 2004; van der Zwet et al., 2009). It was felt that this could be achieved through educating patients about the relevant issues (McCall-Hosenfeld et al., 2014).

DISCUSSION

The identified literature showed GPs' experiences and management of social problems within their consultations. GPs discussed factors which prevented and facilitated them in breaching social issues with their patients, and offered their thoughts on care management and treatment options. GPs also discussed the skills they utilise when working with social problems, some of the difficulties they

personally face, and possible system improvements within primary care for the management of social issues.

Although GPs tended to be in agreement on many of the above issues, the literature review also suggests that GPs are in conflict with their views on how to manage social issues. For example, there were some different views on whether the social problems should be managed by GPs within primary care, or through interventions within the community; possibly different opinions depending on the type of social problem. There were also some differences about GPs being open about their emotions or remaining stoic and emotionally separate from their patient encounters.

These professional and personal differences with how GPs manage social problems may mirror a wider issue of the confusion and uncertainty which GPs may feel about the prevalence of social problems within general practice. The discomfort and uncertainty about how to manage their personal emotional reactions to their patients' social problems could potentially have negative effects on GPs and more practically, the difficulties of managing social issues are putting trainee doctors off entering general practice (Krishnamoorthi, 2010). This issue therefore needs to be highlighted further and further support given to GPs working with social problems within primary care.

The Present Study

Following on from the above points highlighted in the literature search, it is important to find out more about how GPs view and manage social problems within general practice, and also the ways in which the system could be improved and how GPs

could be supported further. There is a substantial body of literature on GPs' management of depression (McPherson & Armstrong, 2012), but little else on non-medical and non-mental health issues. Loneliness as a social problem is expected to rise as the ageing population grows (Gill & Taylor, 2012), and identifying and addressing loneliness is increasingly becoming a government priority (Department of Health, 2012). Furthermore, it is evident that lonely people have more physical health complaints (e.g. Thurston & Kubzansky, 2009), and seek assistance from their GPs more than those who are not lonely (Ellaway et al., 1999).

Despite this, GPs' views of addressing loneliness in their consultations is a relatively under-researched area. Research from the Netherlands has started to introduce this topic (van Ravesteijn et al., 2008; van der Zwet et al., 2009), however the participant samples have not been fully representative of age, gender, and cultural background. In addition, these studies do not focus specifically on older adult patients, but explore the general population of patients. There is currently no similar research within the UK NHS, which operates differently to the Dutch healthcare system. Therefore, there is still a need to build upon the evidence-base of GP views and barriers towards addressing loneliness with their older adult patients within the UK NHS system. Furthermore, there is a gap in the literature with regards to: the next steps in GPs addressing loneliness; what, if any, further support for GPs is needed in terms of managing social issues; and how the current system could be improved to help both GPs and patients.

This study therefore aims to contribute to the evidence-base and add to what is lacking in the current literature. Broadly, it aims to explore GPs' experiences of

encountering loneliness within their older adult patients (aged approximately 65 and over).

More specifically, the research questions will focus on:

a) GPs' views and experiences around addressing and managing loneliness within older adult patients during their general practice consultations;

b) What improvements can be made within the healthcare system and how GPs can be supported further in managing loneliness within general practice.

CHAPTER 2: METHODS

**Philosophical Underpinnings**

This section will outline and explain various different philosophical viewpoints that are often undertaken in social science research. The researcher's personal positioning in relation to these will then be explored, with a view to providing a philosophical rationale for methodological and design decisions discussed later in this chapter.

Ontology, Epistemology, and Philosophical Paradigms

Ontology is generally considered the study of reality, focusing on reality's very nature and determining *what* is reality? (Guba & Lincoln, 1994). Epistemology is a term that describes the study and justification of knowledge (Carter & Little, 2007), or "how we know what we know" (Crotty, 1998). In research therefore, ontology may ask whether the researcher believes that there is a single truth or whether there is no one single reality, or somewhere in between. Epistemology might then continue with this thinking, and consider how this reality can then be known, for example can reality be measured or does it need to be interpreted, or somewhere in between? Ontological positions range on a spectrum, from realism to relativism, the former advocating that there is a truth to be found, and the latter positing that truth is constructed with others through the process of social beliefs and experiences. Epistemological positions can similarly be thought of as on a spectrum, ranging from objectivist to subjectivist, the former favouring empiricism and lack of researcher influence, while the latter emphasising the existence of multiple realities and the influence of the researcher.

Guba and Lincoln (1994) state that there are four main philosophical paradigms which can be considered in relation to how research is conducted: positivism, post-positivism, critical theory, and constructivism. These four paradigms are made up of ontological and epistemological stances, and can be positioned on a spectrum ranging from the positivist idea that there is one single truth/reality to the constructivist idea that there is no single truth/reality (see Figure 2).

Figure 2: Spectrum of four main philosophical paradigms

"There is a single truth/reality"   **"There is no single truth/reality"**

Positivism   Post-positivism   Critical theory   Constructivism
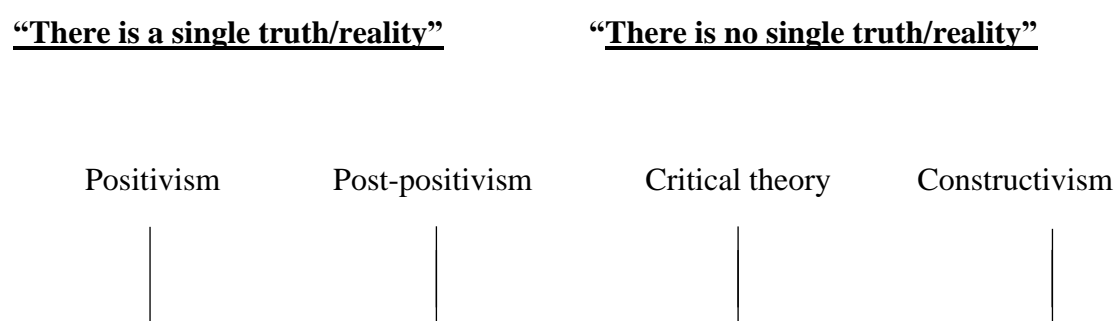
Positivism dictates that there is a single truth or reality which can be discovered (Guba & Lincoln, 1994), and that this reality can be researched through empirical or experimental methods (Miller, 1999). Positivist researchers do not believe that they influence their participants or their research, and therefore adopt an objective external stance to their research (Guba & Lincoln, 1994). Post-positivism also assumes that there is an existing truth/reality, but that it cannot always be measured. It offers some revisions to the extremities of positivism, for example it does not attempt to merely prove ideas, but rather to also reject null hypotheses and accept that theories can be changed and revised (Guba & Lincoln, 1994). The usefulness of positivist and post-positivist viewpoints within social science research has been widely debated, and a

common criticism is that interpretation in some form cannot be avoided when attempting to describe experience (Houghton, 2011).

Critical theory purports that reality has been shaped over time by social context, for example by cultural, political, economic factors (Guba & Lincoln, 1994). It is commonly used to discuss feminism (Allen, 2013) and Marxism (Ghiraldelli, 2006). Guba & Lincoln (1994) state that there is communication between researcher and participants within this paradigm, and that the researcher is thought to influence the research process. Its ontology focuses on historical realism, meaning that this standpoint is shaped by the political, economic, gender, and cultural values of the time in which the research is carried out (Guba & Lincoln, 1994). Due to this approach generally being crystallised in time, it can offer a useful insight into research exploring a phenomenon in one specific frame. However, it may be a restrictive approach for research examining concepts which are more fluid across time spans and cultures, and may not offer a broader social viewpoint as an approach like constructivism might.

Constructivism is borne from a relativist ontology and a subjectivist epistemology, meaning that individual truths are created from social contexts and experiences, and that an inductive approach is generally used to interpret these realities (Guba & Lincoln, 1994). Specifically, social constructivism suggests that knowledge is something that people construct together, rather than something that is merely possessed in individual minds (Gergen, 1985). This philosophy therefore purports that meaning is derived from the interaction between participant and researcher, and that the researcher cannot remain an external observer without having any influence

on the findings (Guba & Lincoln, 1994). This research project aims to explore GPs' individual experiences and perceptions of a phenomenon, and how they construct their reality in relation to their context and interactions with their patients and other professionals. Furthermore, this study does not seek to identify a 'truth' or 'reality' regarding the topic of loneliness in primary care, but rather to understand how GPs individually experience it. It also aims to transcend time-fixed ideologies in order to be able to consider broader social interactions and constructions from the individuals' points of view, and not be restricted within a particular political ideology or timeframe. Therefore, a social constructivist framework would be most appropriate for this study, and would also correspond with the researcher's personal positioning (discussed next) as well as the design of the study (discussed later in this chapter).

Positioning of Researcher

I am a white, European-born female aged under 30, studying for a Doctorate in Clinical Psychology. Although my demographics may not immediately seem as though they would greatly affect my interviews with GPs, I have been considering their influence on my research throughout the study process. I wondered whether the aspects of my demographics which were visible to the GP participants might have swayed their decision in some way to either take part or not take part in the study. Once recruited, the visible aspects of my demographics may also have influenced the way in which GPs responded to my questions or their decision as to how open to be in the interview. For example, during initial meeting and pre-interview conversation, one of the GPs mentioned that I looked young. This comment may have had a number of connotations, such as viewing me as unintimidating and the GP therefore being more open during the interview. Conversely, it could also have worked against

me if the GP considered me 'too young' to be able to hear some of what they had to say about working with older adults and loneliness, and may have therefore left some more difficult information out in case I was also 'emotionally young'.

I was aware that my Clinical Psychology training and my concurrent experience of carrying out therapy on placements would inevitably affect how I interacted with everyone in my life outside of the course, and this included the GP participants in my study. I considered how this might have influenced the way in which I asked questions and expected replies from GPs, for example approaching concepts from a more psychological, rather than medical, angle, and pursuing certain threads of conversation over others. From my various placements, I had experienced the sometimes-great distinction between psychologists and medics, and therefore may have brought my uncertainties and fears about this into the interviews with GPs. I was also cautious about falling into therapeutic habits and allowing the interview to become akin to a therapy session. Despite this being something I thought about a lot during the interviews, I did sometimes notice myself slipping into empathetic reflecting with the GP participants. This may have affected the GPs' subsequent decision to open up more or less during the rest of the interview.

I recruited some GPs who had previously worked in the same research department as me during my time previously as a research assistant. Although we had not worked together directly, we knew each other all the same. Although this proved to be useful for initial recruitment of participants, I was aware that having had a prior relationship with these GPs would affect the interview and research process with them. I wondered whether this might affect the interview in a positive way, for example

having knowledge of and trust in the researcher may allow participants to open up more about their opinions; or whether it might do the opposite and dissuade participants from speaking about potentially embarrassing or less socially acceptable issues for fear of being judged by someone they know. In my experience of conducting the interviews I felt that the former was true, and that I was able to have more in-depth, honest interviews with the participants whom I had known. I am aware that this may also have been to do with me knowing them and therefore being more comfortable to probe on more difficult questions or avenues of enquiry.

My interest in this particular topic arose from my previous role as a research assistant working on studies in primary care and older adult wellbeing. From conducting interviews with older adults, I began to sense that some of them were lonely but would never state this outright or use those words. As part of the research studies, I asked questions about their use of primary care and presentation at their GP practice. From this, I have some prior knowledge and assumptions of how older adults may communicate their loneliness and how they might present within primary care, and I made sure to be aware that this did not skew which questions I asked the GPs, how I asked them, or how I then responded to their answers.

I believe that a number of factors making up our social context do influence how we perceive our truth and reality, and that I as a researcher will inevitably influence both my participants and the research process. I am also looking at GPs' lived experiences of a phenomenon, which will be unique to their experiences and context, and I do not believe that there is one truth or reality about it that can be discovered. Rather, I am hoping to interpret the realities of the GPs which arise on that particular day and time

of interview, and consider the meanings which underlie the occurring events. Due to my social constructivist leanings, I conducted this study with constructivist philosophies in mind, believing that the GPs' constructions of their reality can only be extracted from the interaction between them and me. As part of this, I kept a reflective journal during data collection in order to record my reflections and learnings from the interviews, which I will use alongside my data in order to frame it in the context in which it took part.

Design

Before deciding on research design, it is important to note some primary considerations. Firstly, the research question should determine the design, and the most appropriate design to satisfy the research aims should be selected (De Vaus, 2001). Secondly, it is argued that epistemological leanings and research design are linked, and should therefore be considered in conjunction (Vasilachis de Gialdino, 2009; Scotland, 2012).

Quantitative research seeks to explain phenomena through the use of empirical methods, experimental design, and gathering of numerical data (Cohen & Manion, 1980; Creswell, 2014). Quantitative designs are useful in providing evidence-based results, such as using Randomised Controlled Trials (RCTs). They are also able to recruit large sample sizes and therefore display validity of their findings. On the other hand, qualitative research is more explorative, and attempts to describe a person's experience or the meaning they give to situations in a more in-depth and subjective way (Creswell, 2014). Qualitative designs are also useful in being able to pursue

topics of interest (for example through follow-up questions in an interview), which can go further to elucidate complex views and attitudes (Pope & Mays, 1995).

Due to the explorative nature of the research question, a qualitative research design was selected. As the research question seeks to explore the experiences and views of GPs' encounters with loneliness in older adults, qualitative methods were used for their ability to conduct initial explorations, and understand people's experiences and interpretations of events (Sofaer, 1999). Qualitative methods also allow simultaneous data collection and analysis, which is advantageous for the exploration of new areas of interest as it allows for the iterative development of topic guides as new themes arise (Pope, Ziebland, & Mays, 2006). This is useful in allowing further elaboration of GPs' views, and elucidation of the meanings which they ascribe to their experiences. As the research will identify themes and meanings from participants' experiences, rather than testing a theory, a bottom-up inductive approach is most appropriate. This ensures that meanings are being interpreted from the data itself, rather than seeking to prove or disprove a theory with the data (Creswell, 2014).

While quantitative research designs tend to adopt a Positivist philosophy, qualitative research generally tends to have leanings towards critical realist and social constructivist epistemologies. This is because qualitative methodologies tend to reject the notion that phenomena can be measured objectively, and instead attempt to explore the subjective constructions of meaning for individuals (Robson, 2002). As this research seeks to look at individual experiences and views, a qualitative design would complement a social constructivist philosophy, with a starting assumption that

there is no singular reality that can be known, but rather that there are many different realities and meanings which are socially constructed.

The above argues, therefore, that a qualitative, inductive design is an appropriate fit for both the research question and the study's epistemological leanings.

Participant recruitment and procedure

Sampling

Participants were GPs working in the United Kingdom, purposively sampled for diversity in age, gender, years of experience, ethnicity, and working in urban or rural settings. A representative sample allows for the exploration of different views and experiences, and contributes to the rigour of the research study (Anderson, 2010). It is also in line with the social constructivist leanings of this research, due to the belief that there is no single reality to be found and therefore different people's experiences may exhibit different truths and realities.

Based on experience of approximate numbers required for saturation and timescale of this research, similar studies in the field, and recommendations for medium-sized studies using thematic analysis (Braun & Clarke, 2013) the aim was to recruit approximately 15 GPs, with a maximum of 20.

Inclusion and Exclusion Criteria

GPs were eligible to take part in the study if they were:

➢ Fully qualified GP

➢ Currently working as a GP with patients

➢ Working in England

➢ English-speaking

GPs were not eligible to take part in the study if they were:

➢ Medical students or GP-in-training

➢ Retired or ex-GPs

➢ Non-English-speaking

The interview questions focused on GPs' experiences of working regularly and recently with patients, and this could not be guaranteed with students or retired GPs; they were thus excluded. Non-English-speaking GPs were not able to be included due to lack of funding for translation costs for this thesis.

Recruitment Methods

GPs were recruited using a three-pronged approach: use of researcher contacts, snowballing, and purposive sampling using online searches. Initial interviews were conducted using researcher contacts as this has been shown to aid in participation rates in doctors (Asch, Connor, Hamilton, & Fox, 2000). These were GPs who the researcher had previously known in a professional capacity within a research department and who had expressed an interest in the study. Snowball sampling was utilised by asking each GP participant if they knew other GPs who might be interested in taking part, and to forward on the study information if so. Once the initial phase of recruitment from researcher contacts and snowballing had taken place, the demographics of recruited GPs were reviewed and gaps were identified – for example, the majority of the GPs worked in urban practices, and more were needed from rural practices. Purposive sampling was consequently used to identify and

recruit GPs working in rural areas. This was done through online searches of GP practices in rural areas, and emailing the GPs within those practices.

Recruitment Procedure

All potential GP participants were initially invited to take part in the study by an email briefly explaining the study with an attached Participant Information Sheet (PIS; see Appendix A). In the case of no response after two weeks, GPs were sent a reminder email. In the case of having not had either a reply or a refusal from a GP after a further two weeks, they were followed up with a telephone call if appropriate. An appointment was set up with the GP to conduct the interview at a time and location convenient for them. At the beginning of the appointment, the researcher explained the study and invited any questions the GP had about the study or process. Consent was explained and obtained using a consent form (see Appendix B). The interview was then conducted and recorded on an audio-recording device. The interviews were initially conducted in person, face-to-face. However, some GPs asked if they would be able to participate in the interviews over the telephone instead due to time constraints. As a result of this, an amendment was requested from the University of Essex Ethics Committee (see Appendix C), in order to incorporate telephone interviews into the data collection process. After this was approved, GP participants were given the option of taking part in either a face-to-face interview or a telephone interview.

Qualitative research commonly uses data saturation to establish participant sample size for recruitment (Morse, 2015), however its ability to supply researchers with certainty of this has been questioned (Saunders, Sim, Kingstone, Baker, Waterfield,

Bartlam, Burroughs, & Jinks, 2017). Furthermore, it is important to consider a study's research question and philosophical standpoints when establishing whether to guide recruitment using saturation. Due to the assumed difficulties with recruiting GPs and probability of shorter interview lengths, saturation was not claimed to have been used as part of recruitment. Furthermore, a constructivist viewpoint would argue that there may not necessarily be one truth that all participants will agree on, and this thesis does not aim to isolate one shared truth, therefore the use of saturation was not pursued.

Data collection

Semi-Structured Interviews

Semi-structured interviews have a set of topics which the researcher wishes to ask about, but are also flexible enough to permit the conversation to lead to other topics, or to explore issues in more depth. They are generally used in qualitative research and aim to answer "why" questions (Fylan, 2005). Therefore in this study data were collected through use of semi-structured interviews to allow for the exploration of key topics whilst permitting further probing of other issues which may arise during the interview.

Topic Guide

The topic guide for the semi-structured interviews was initially informed by current relevant literature in the field (see Appendix D). It was purposefully broad to allow exploration of different views and experiences that the GPs brought to the interview, however covered the general questions that were important to cover in the interviews. The initial topic guide covered the following areas:

- GPs' understanding of and views of the term 'loneliness'

- How GPs experience/reactions to older adults exhibiting loneliness within their consultations

- Barriers that GPs find in raising the issue of loneliness with older adults in their consultations

- How GPs manage the issue of loneliness in older adults in their consultations

- What GPs feel is missing from the system at the moment? How can things be improved so that GPs feel better equipped to manage loneliness in their work?

A pilot interview was conducted with a person who used to work as a GP. They were no longer eligible for the study, however they had experience of being a GP and could therefore provide feedback about the topic guide and interview questions, adding an element of rigour to the development of the topic guide. As a result of this pilot interview, some questions were revised to clarify their meaning. As the interviews progressed, the topic guide was developed iteratively through the emergence of new topics and ideas from the previous interviews. Through talking to GPs about the topic of loneliness, new avenues of inquiry invariably arose and these were then incorporated into the topic guide to be explored with remaining participants. For example, GPs often discussed the idea of whether it was their role to manage social issues; consequently, a question about how the GPs view their role within patient loneliness was added to the topic guide.

Interview length was taken into consideration when developing the topic guide. Similar literature in the field interviewing GPs had a range of interview length

between 12 and 39 minutes (van Ravesteijn, Lucassen, & van den Akker, 2008), and feedback from the pilot interview suggested that interviews should not be pitched as too lengthy. With the assumption that GPs may have limited time to offer, the topic guide remained broad, flexible, and shorter than traditional qualitative interviews so as to be able to explore all areas if time allowed, but also to be able to glean the main pieces information in a short space of time if necessary.

Individual Interviews

Interviews were conducted individually with GP participants, rather than using focus groups, for a number of reasons. Firstly, interviewing GPs together in a focus group may affect their behaviour and answers to the interview questions. For example, some GPs may feel social pressures to conform to the group and answer questions in a certain way. They may also be less likely to divulge more controversial or less socially-appropriate views and opinions. Conducting the interviews individually would therefore give GPs the security and confidentiality to allow them to voice their opinions freely. Secondly, GPs were encouraged to use patient examples in their answers, and due to the sensitive and confidential nature of discussing patients, it was more appropriate to discuss these examples on a one-to-one basis. Lastly, GP interviews were difficult to schedule due to GPs' time constraints and were therefore scheduled at a time and location most convenient to the GP. This mostly took part at the GPs' individual practices or over the telephone. This meant that a focus group would be difficult to set up practically, and that individual interviews were the most appropriate method for this participant group.

Once the audio-recorded data were collected, they were transcribed by the researcher to allow for initial familiarisation with the data.

Analysis

Qualitative data analysis comprises many different methods of analysing data. It is important to consider the research question and study aims when selecting the method of qualitative analysis (Starks & Trinidad, 2007). This section will discuss some widely-used methods of qualitative analysis and explain why the chosen method was selected for this study.

Other methods of qualitative analysis

Grounded Theory (GT) is a method of developing a theory by beginning with a general research question and iteratively building concepts and ideas as the method goes on (Strauss & Corbin, 1994). The key difference between GT and other types of qualitative analysis is the development of theory, however GT also offers a systematic way of collecting and analysing data, as well as veering away from simply describing data but rather giving more variation and depth to it (Strauss & Corbin, 1994). Conducting GT takes a lot of time and effort, and researchers are often criticised for in fact conducting thematic analysis rather than full GT (Green & Thorogood, 2014). GT has also been criticised for 'invention' of theory due to variable researcher interpretations, and it has been questioned whether what GT creates is in fact 'theory' (Thomas & James, 2006). Grounded theory was not used in this study as the research question wanted to understand GPs' experiences and views, rather than develop a theory about this topic.

Interpretative Phenomenological Analysis (IPA) is an idiographic method of qualitative analysis; this is, it aims to understand participants' individual and personal inner psychology and 'lived experiences' (Reid, Flowers, & Larkin, 2005). It incorporates both the interpretation of the participants' experiences by the researcher, and a phenomenological approach which looks at participants' subjective, rather than objective, explanations (Brocki & Wearden, 2006). Due to this, IPA tends to use smaller sample sizes, as Collins and Nicolson (2002) argue that larger sample sizes may lose "potentially subtle inflections of meaning" (pg. 626). Although IPA is useful for understanding individual accounts and experiences in an in-depth way, researchers do not always interpret the data at the same level of depth, and there can be inconsistency in this method (Brocki & Wearden, 2006). The present study did not use IPA for two reasons. Firstly, IPA is idiographic, focusing on unique experiences of individuals, whereas this study aims to encapsulate a range of views, as little is known on the subject. Secondly, IPA is formulated towards a smaller sample size and a degree of homoegeneity in order to allow depth of data interpretation. However, this study is more suited to a larger sample size to allow for different views and experiences, as well as a diverse sample.

Thematic analysis and process

Thematic analysis (TA) is a flexible form of qualitative analysis, which allows for different decisions about epistemological stance, inductive vs deductive approach, as well as angle and depth of analysis (Braun & Clarke, 2006). However, TA's flexibility can also prove disadvantageous as the potential range of things that can be said about the data is broad, thus it may be difficult for researchers to know what to

focus on. This can be managed by being clear about the research question and being consistent and rigorous in the coding process (Braun & Clarke, 2006). Due to the relatively unchartered nature of this study's research question, TA was chosen as the method of analysis for its flexibility to examine and record themes within the data. By having the flexibility to choose an approach which allows rich thematic description of the data, key themes from the topic area can be reported (Braun & Clarke, 2006). The research question focuses on GPs' cumulative views and experiences, therefore TA was the most appropriate method of analysis to analyse across datasets, and understand these more surface-level, rather than in-depth, topics and themes. Furthermore, due to the lack of previous research on this topic, an inductive 'bottom-up' approach was chosen to glean meaning from the data itself, without a starting theory or hypothesis. This was conducted by carrying out data collection and analysis simultaneously, allowing for exploration of new avenues of enquiry as new topics arise with each interview. I, as the researcher, also made the decision to transcribe all the interviews myself in order to begin the process of data analysis by early familiarisation with the data.

TA was conducted manually rather than using electronic qualitative analysis software, due to researcher preference. The process of analysing the data using TA followed the six steps proposed by Braun and Clarke (2006):

1. *Familiarisation with the data:* This included transcribing the data, then reading through it and making initial notes. The initial notes helped to form ideas in mind of predominant ideas and narratives of the transcripts.

2. *Generating initial codes:* Initial codes were produced from data which was deemed interesting or noteworthy. Codes were broad and retained context at this stage. Coding was conducted by a single coder, the researcher. This approach was selected as it favours a more constructivist view that there are multiple realities and that there is no one definite truth that can be verified by two coders. Sections of interest were marked out using a highlighter and notes regarding the text was made in the right-hand column (see Appendix E for an example).

3. *Searching for themes:* This step comprised a broader level of analysis, in which codes were combined to form larger themes. Transcripts were printed and coded sections were cut out separately in order to be able to move codes around and group them into tentative themes. After most of the codes had been classified into themes, some themes came together to be grouped into a larger over-arching theme. The themes were therefore termed 'sub-themes' and 'over-arching themes'.

4. *Reviewing themes:* This step involved refining the existing themes by deleting some or combining others into one larger theme. This was conducted by reviewing the current sub-themes and over-arching themes and re-sorting them if necessary, whilst also deleting any themes that were superfluous or did not add to the analysis.

5. *Defining and naming themes:* Themes were given names which explained what the theme was about and also encapsulated the 'essence' of it. This

process also required review and refinement over time, and theme names were changed to give a better sense of the message which that theme conveyed.

6. *Producing the report:* This step is not merely descriptive; the write-up of the analysis aimed to present the findings so as to argue a point in relation to the initial research question, as well as the existing literature.

Member Checking

Rigour and credibility of research findings can be sought through the use of 'member checking', which is the process of asking participants to examine the findings from their analysed data so as to confirm meaning and validity (Birt, Scott, Cavers, Campbell, & Walter, 2016). However, the constructivist philosophical leanings of this thesis imply that it is not seeking one ultimate truth, but rather how each participant experienced the phenomenon at the time of the interview. Therefore, asking participants to corroborate their expressed experiences at a later date would suggest that their opinions at the time of interview were a continual truth or reality, which would be in discord with the philosophical framework, thus this method was not used.

Ethical considerations

Ethical approval was sought and obtained from the University of Essex Ethics Committee (see Appendix F). As this study only involves the recruitment of staff, NHS ethical approval was not required. However, Health Research Authority (HRA)

approval was sought and obtained in order to be able to use GPs' NHS email addresses and to interview GPs on NHS site premises, such as at a GP surgery (see Appendix G).

Consent was taken from all participants with the use of consent forms. It was explained that participation is voluntary and that participants may withdraw from the study at any point. Participants were also made aware that interviews are confidential, except where the research team deems that either the participant or somebody else are at risk of harm. Whilst the audio-recorded interviews were being transcribed, the data were stored as password-protected files on a password-protected computer. Once interviews had been transcribed and transcripts checked for accuracy, the audio recordings were destroyed. Transcripts were anonymised and password-protected, and stored electronically on a password-protected computer.

A potential implication for participants was the sensitive nature of the interview questions, which some GPs may have found upsetting. Participants were therefore given the option to debrief with a clinician at the University of Essex who was external to the thesis project at any point after completion of the interview. A further ethical consideration was that some of the GP participants were known to the researcher, and may therefore have felt more pressure to take part in the study than the participants who did not know the researcher. This was managed by keeping the recruitment process identical for all potential participants, and informal methods were not used to recruit participants known to the researcher.

It is widely debated whether research participants should be reimbursed for their time and effort in taking part in studies (Grady, 2010; Ripley, 2016). Offering participants reimbursement in the form of money or vouchers may exert coercive power over their decision to consent and also bias the data (Russell, Moralejo, & Burgess, 2000), however it is also argued that an appropriate amount of reimbursement shows appreciation for participants' time and effort spent on the study (Grady, 2010). When participants themselves were asked whether they believe research participants should in general be reimbursed for their time in the study, the majority of them disagreed with this. Instead, they argued that non-monetary offerings can display recognition for their contributions instead (Russell et al., 2000). Furthermore, a review found that most studies recruiting doctors did not offer their participants any incentives, or if they did, the incentives were small. They found that recruitment rates were unaffected by whether the doctors were offered incentives or not (Asch, Connor, Hamilton, & Fox, 2000). Therefore, as this thesis is recruiting GPs, it was decided to not offer any financial incentives to participants. As shown in the literature, it would be unlikely to improve recruitment rates, and it would also remove the ethical dilemma of coercive participation. Instead, GPs were offered to be sent a summary of the study findings.

Dissemination

The findings of this thesis will initially be fed back to the GP participants in the form of a brief findings summary sent by email. This will not only serve to inform them of their peers' views on the topic, but may also influence service provision due to GPs' roles as clinical commissioners. The work will be disseminated to peers in the University of Essex Clinical Psychology Doctorate and other academics via a presentation at the Health and Human Sciences Staff and Student Conference. The

research will also be written up in the form of a thesis for completion of the Clinical Psychology Doctorate, and will be made available in print as well as online. Subsequently, the research will be re-formatted and submitted for publication in peer-reviewed journals within the area of primary care, social care, or older adults and aging.

Budget

There was no requirement for a budget or funding applications for this study. Costs incurred were for printing paperwork and for travel, both of which were covered by the researcher.

CHAPTER 3: FINDINGS

Sample Demographics

In total 19 GPs were recruited to the study. The demographics of GPs are illustrated in Table 4.

Table 4: Demographics of GP Participants

	Sex	Age	Years of experience	Rural/Urban practice	Ethnicity	Interview
GP1	F	31	1.5	Urban	White British	Face to face
GP2	F	31	1	Urban	White British	Face to face

GP3	M	53	24	Rural	White British	Face to face
GP4	F	29	1.5	Urban	Other Asian background	Telephone
GP5	M	35	5	Urban	White British	Face to face
GP6	M	57	26	Urban	White British	Face to face
GP7	F	62	32	Urban	White British	Face to face
GP8	M	57	29	Urban	Indian	Face to face
GP9	F	38	7	Urban	White British	Telephone
GP10	F	56	27	Urban	White British	Telephone
GP11	F	31	3	Rural	White British	Telephone
GP12	M	52	25	Rural	Other Asian background	Telephone
GP13	F	42	10	Rural	White British	Telephone
GP14	F	45	18	Rural	White British	Telephone
GP15	M	57	29	Urban	White British	Telephone
GP16	F	31	2	Rural	White British	Face to face
GP17	M	55	26	Urban	White British	Telephone
GP18	M	49	20	Urban	White British	Telephone

GP19	F	43	3	Rural	White Irish	Telephone

The sample was fairly evenly distributed across sex, with eight males and 11 females. Similarly, there was an even distribution across age ranges, with six aged 26-35; four aged 36-45; four aged 46-55; and five aged 56-65. Years of post-GP qualification experience ranged between one year and 32 years, with an average of 13 years' experience. Seven GPs practised in rural locations, while 12 practised in urban areas. The majority of GPs (15) identified as White British, while four GPs identified with other ethnicities (White Irish, Indian, Other Asian background). Eight interviews were conducted face-to-face, and 11 took place over the telephone due to distance and/or GP preference.

The length of interviews varied between different GPs. The shortest interview lasted 13m45s, and the longest interview lasted 40m02s, with an average length of 25 minutes. These timings are similar to another study in the field interviewing GPs about loneliness (van Ravesteijn et al., 2008), which had interviews ranging between 12-39 minutes with an average of 24 minutes. This perhaps reflects issues with recruiting and interviewing GPs discussed in further detail in Interview Reflections below.

Interview Reflections

As part of the process of conducting interviews with GPs, I kept a reflective diary to note my observations and feelings from each interview. One main thing which I noticed repeatedly coming to my attention was GPs' discomfort with questions relating to their personal feelings and emotions in response to lonely patients. While

they directly answered questions about their patients and the health system, when it came to being asked about their feelings and emotions for the most part GPs showed avoidance and distancing from those questions. For example, they talked about something different to what was asked in the question, or answered briefly before changing the topic and talking about something else. Initially this was frustrating, but it was useful for me to reflect on our different professions and how that may be influencing the interview process. As a Clinical Psychology trainee, I am being trained to think and reflect on emotional issues in great depth, which I noticed that I was also expecting of the GPs when I first started collecting data. However, I soon realised that this was something that most of the GP participants were doing and this prompted me to further consider the reasons for this. GPs have very different training as medics and are understandably more aligned with the medical model rather than psychological models; their training also mainly centres around their patients rather than equally considering their own personal responses to their patients (with the exception of the use of Balint groups). Therefore, it may not be routine for GPs to check-in on their own feelings and responses to patients, and there may be an understandable discomfort and resistance to talking about something outside of their comfort zone.

I also noticed that GPs tended to answer questions quite briefly and to the point, without much elaboration, and often needed prompting. This initially made for shorter interviews than I would have expected (see above regarding interview lengths) and this was something I reflected on early in the interview process. This may have been to do with a number of reasons. Firstly, GPs tend to be highly busy during their working day and may only have time to take part in shorter interviews,

thereby giving shorter responses. Secondly, GPs may be used to mainly working in short consultation timeslots and having brief conversations, mirroring the brevity with which they answered the qualitative interview questions. This style may also reflect GPs' training in the medical model and skills in problem-solving, creating a fast-paced, goal-oriented way of thinking and conversing. In keeping with the constructivist viewpoint of this study, I allowed the GPs to direct the level of detail with which they answered the questions and how long they wanted the interview to last, with the belief that my reality of how long answers and interviews should be may not necessarily be their reality of how long they should last. Throughout the interviews I was careful to keep in mind that although we were both healthcare professionals, we had different training and different jobs that may lead to different thinking styles and viewpoints, and to be careful as to not inflict my style and views upon them as participants.

Conducting both face-to-face and telephone interviews with the GP participants highlighted the difference between the two methods of data collection. I noticed that GP tended to open up more in face-to-face interviews, perhaps due to the human interaction, pre-interview conversation, and body language. As GPs perhaps felt more comfortable with the interviewer having met them in person, their answers were more in-depth and the interview tended to last longer. Therefore, while telephone interviews were useful in being able to recruit GPs who would not have otherwise been able to take part, I found that the face-to-face interviews provided a more relaxed interview for the GPs and allowed them to speak more openly.

Themes

In total, five over-arching themes and 14 sub-themes were identified from the data (see table 5).

Table 5: Over-arching themes and corresponding sub-themes

Main Themes	Sub-themes
Loneliness is outside of our control	More than just a physical state
	Some people are more likely to be lonely than others
	Why are we a lonely society?
A Westernised approach	A curative system
	Medicalisation of a social problem
	Whose responsibility is it?
A difficult topic to talk about	GP barriers
	The vicious cycle of stigma
GP as human	GP emotions
	Powerlessness
	Stress and burnout
	Self-protection
A need for systemic change	GP support
	The wider system

1. <u>LONELINESS IS OUTSIDE OF OUR CONTROL</u>

This theme contains three sub-themes within it, and outlines how GPs construct the idea of loneliness as a phenomenon, with a wider idea that loneliness is something that is complex and mostly outside of our control, perpetuated by life circumstances

and the way in which our society operates. This includes definitions of loneliness, potential causal factors, and discussions about how loneliness has been perpetuated within our society, as well as the future of loneliness within a growing ageing population.

More than just a physical state

The GPs interviewed tended to agree that loneliness was more than a physical state of social isolation. They discussed that although some people felt lonely when they did not have others around them, that people could also feel lonely when surrounded by other people. In this way, the definition of loneliness became more of a subjective feeling, rather than a clear-cut physical state. One of the GPs described it as:

> *"a feeling or sense of being by oneself .. not just physically, but that can be mentally, emotionally, feeling unsupported or without people around you. But I think it's also the emotional loneliness as well as the physical one, so people that maybe live with someone but they don't get on or they have carers coming in, but that's not necessarily 'real' human contact"*
> (GP16, female, rural, Years of Experience (YOE): 2))

GPs explained feelings of loneliness even when not socially isolated as the absence of a deeper or more meaningful relationship or connection, for example through feeling valued, as well as being able to confide in and open up to someone, and them in you. A GP described it as:

> *"Somebody who really cares about the patient or you, somebody who knows you, understands what you've been through, what you are going through, what difficulties you might have, somebody who will come out to bat for you, somebody with a supportive relationship, uh.. all those things, you know, a caring relationship"*
> (GP10, female, urban, YOE: 27)

GPs also stated that it was equally possibly for people to be socially isolated but not feel lonely, for example if it is out of choice:

> *"I remember a patient and I said "do you like living on your own?", he's quite elderly.. and he said "it's delicious" – it's an unusual word to use, but it suited him fine, he liked the independence and the freedom"*
> (GP6, male, urban, YOE: 26)

However, one GP held the view that loneliness was purely a state of physical social isolation and not having others around them:

> *"to be honest I haven't.. thinking about the patients that I have at the moment, it does tend to be that they don't just have people around. They don't come just saying "oh there's people around me but I still feel lonely because I can't talk to them" – it is that there isn't anyone particularly around them"*
> (GP13, female, rural, YOE: 10)

The majority of the GPs interviewed believed that loneliness was a complex and subjective state of being, which may be present in social isolation but can also be present when a person is surrounded by others. The main argument for a person feeling lonely whilst not socially isolated was a lack of significant and meaningful, rather than surface-level, relationships.

Some people are more likely to be lonely than others

GPs spoke about the individual, circumstantial, and health system factors which may make certain people more vulnerable to experiencing loneliness. One GP discussed the impact of gender, with men tending to be less sociable than women:

> *"It's just something that I've seen in my practice over the years; men are much harder to motivate. Erm, particularly widowed men, the women tend to have, it's a huge generalisation, but the women in their lives*

tended to be the talkers and the socialisers, so when that's gone, they just

feel bereft and that's not something that they've ever really done"

(GP19, female, rural, YOE: 3)

GPs also discussed the presence of mental health conditions being co-morbid with loneliness, both as potential causal factors for loneliness, but also as results of loneliness. One GP thought that mental health conditions may hinder a person's ability to socialise and ask for help if they needed it, thereby further compounding their loneliness:

"people with mental health problems for example can feel very lonely

because they're not able to interact and reach out to those around them"

(GP1, female, urban, YOE: 1.5)

Personality differences were also discussed, and one GP argued that somebody's perception and outlook can impact on whether they feel lonely or not:

"some of it's personal feelings about whether they're more reclusive or

more shy; they might not want a lot of contact. Other people, they're

really desperate to have it and they can't get it, and they perceive

themselves as being lonely"

(GP 15, male, urban, YOE: 29)

Not being able to speak the language was also discussed as an individual factor that can play a role in loneliness. One GP described a patient who could not speak English, which hindered her in being able to integrate and socialise within the local community:

"My normal advice about trying to get her to network.. that's really

difficult when your language is not quite up to it"

(GP8, male, urban, YOE: 29)

GPs talked about life circumstances which can make people more likely to become lonely. For example, spousal bereavement was cited as a frequent predecessor of

loneliness in older adults, as GPs felt that once somebody's spouse had died they had much less social contact and most likely lived alone following that. It was also felt that spousal bereavement sometimes carried with it a loss of a particular role, such as care-giving, and that this loss of purpose could reinforce a sense of loneliness:

> *"I think in the last year I've had a lot of elderly men who have come in quite distraught 'cause they've lost their wives. And that tends to be that they've had a very important role as being a carer, so for a long time they've had that role and that function which has kept them busy, very busy kind of day-to-day"*
> (GP4, female, urban, YOE: 1.5)

Location of residence for patients may also affect their ability to access services or social opportunities:

> *"they might be geographically more isolated, so they might be living in a village or a hamlet, and so to even access some of the social opportunities, physically there may be a barrier to get there"*
> (GP16, female, rural, YOE: 2)

One GP also wondered whether contact with healthcare professionals is becoming increasingly more impersonal due to pressures and targets, and if so, whether this may compound feelings of loneliness when lonely people come into the GP surgery and are met with impersonal interaction:

> *"the contact that people have with their health practitioners should be meaningful, but it may not be meaningful in an emotional sense. I mean, particularly nowadays with the way that there's a concern that a lot of the interactions may be quite tick-boxy. So, you know, if somebody comes and they've got some long-term conditions, they've got blood pressure or they've got diabetes, and the GP might spend a large part of the consultation looking at the screen and just ticking off what's been done. And if it was a lonely older or younger person, it might actually make*

them feel more lonely, because they don't feel like they're being regarded
as a person"
(GP7, female, urban, YOE: 32)

Even though this study focused on loneliness in older adults and GPs were asked to think about their older adults patients, some GPs raised the point that they have noticed high levels of loneliness in other populations as well, such as young people and single parents:

"I know that this is older adults that you're talking about, but even
younger people and children say that they're lonely as well actually"
(GP11, female, rural, YOE: 3)

"what about people like young single parents, those who maybe moved to
a new area and don't know anybody, loneliness comes in other ways who
are maybe not in medical risk groups? But it can still have a really
important impact on people's wellbeing, and therefore their social
functioning"
(GP16, female, rural, YOE: 2)

Why are we a lonely society?

GPs considered explanations as to why such a large number of older people are experiencing loneliness, and more generally why loneliness is a growing problem in our society. Within this was the idea of the changing shape of society, the breakdown of the nuclear family, greater reliance on technology, and that we are gradually interacting less and less with others in a physical sense:

"the demise of corner shops, people connecting online more, people
shopping online more, so the actual rubbing in of shoulders off each other
is diminishing in a physical sense"

(GP18, male, urban, YOE: 20)

"People are living longer, they're living on their own, we no longer have the nuclear family models. People may live alongside their neighbours for years and never know their neighbours, and so they don't have that social environment that perhaps we had a generation or two generations ago"
(GP16, female, rural, YOE: 2)

One GP spoke about older adults, and the issues that we associate with older adults as not being something that is 'fashionable' to talk about, and does not get as much acknowledgement from our media culture as other age groups:

"it's not trendy to donate to old-age charities, or to spend your time with old-age charities or even, and this is probably a very controversial issue and I'm getting off the point I know, but things like the Royal Family etcetera, the younger folk in the Royal Family, they go to childrens' charities and they go to fluffy cuddly things like that, but you'll never really see them in a little old folks' home"
(GP19, female, rural, YOE: 3)

This theme suggests that GPs feel that loneliness in older age is not something that is a priority in our current society, and that this has been propagated by the changing shape of society, the breakdown of traditional family systems, and the greater reliance on technology for things which would otherwise have needed human interaction.

2. <u>A WESTERNISED APPROACH</u>

This over-arching theme has three sub-themes. It refers to the ways in which our healthcare system works primarily with diagnoses and a curative approach, over a preventative approach, and that this is how loneliness is often managed in primary care. This theme also looks at the way in which GPs understand the idea of loneliness

as a social problem that exists within a medicalised role, and how this fits in with our wider cultural ideas of whose responsibility social problems are and how they should be addressed. There appears to be conflict between the medicalised way in which GPs construct loneliness and then the more individualistic, personal way they believe it should be treated, outside of the medical remit.

A curative system

GPs spoke about the physical and psychological effects of loneliness, which are only treated once apparent. GPs were open about their role in diagnosis and treatment of an existing problem, suggesting that their role is only live when there is something apparent to treat rather than preventing a problem from appearing in the first place:

> *"My role is to identify what the problem is, you know, treat the depression if that's a medical problem, and sort of signpost and to direct my patient to somebody who can help. So my role is sort of diagnosing and treatment of illness"*
> (GP10, female, urban, YOE: 27)

It appeared that GPs are working in curative, rather than preventive, system whereby the negative consequences of loneliness can be managed, but loneliness itself cannot:

> *"I don't know if we directly spend a lot of time managing people's loneliness, but we probably spend quite a bit of time managing the consequences of people's loneliness"*
> (GP13, female, rural, YOE: 10)

Treating only the effects of loneliness rather than also addressing the loneliness itself takes up GP time and resources, and crucially does not take away the underlying issue, meaning that these consequences may continue to arise in those patients. Furthermore, it reflects a Westernised approach to healthcare, colluding with the idea

that tangible symptoms and diagnosis are required before treatment (e.g. use of DSM-V).

Medicalisation of a social problem

GPs discussed the issue of loneliness in a highly medicalised way, in the language that they used and the way they viewed loneliness as a medical problem which could be diagnosed and treated like any other physical medical problem. The medical use of language in this context is highlighted when GPs talk about how they tackle the issue in a very logical and medical way, and frame their actions using highly medical terminology:

> *"locally we've got a system here we can refer patients now for assessment for social prescribing if we feel they are lonely, and that seems to work really well actually"*
> (GP15, male, urban, YOE: 29)

GPs also described being products of their training and naturally wanting to construct problems in a medical way, and as a result perhaps looking for medical reasons for patients' problems rather than considering social aspects that may be playing a role, such as loneliness:

> *"and yeah I think just, you know, our training is such that we go for the medical don't we, we've got to go for the medical. And I'm not saying this isn't important, all I'm saying is it tends to, it's sort of secondary isn't it?"*
> (GP8, male, urban, YOE: 29)

One GP spoke about the limitations of medicine in general being synonymous with the limitations of their practice, suggesting that GPs and their work are encased within the limits of medicine:

"I think er gaining an understanding of the limitations of medicine and one's practice is pretty important early on otherwise you get completely defeated"

(GP5, male, urban, YOE: 5)

This poses a problem for any issue within general practice that is not medical, and may force medicalisation of more social issues. Furthermore, if a patient is only presenting with loneliness and it does not fit in with the medical 'template', it is portrayed as something unacceptable to be treating in general practice, and something that is still needed to be treated as a medical issue in order to make it more 'acceptable':

"I think it only really became apparent to me when I was trying to work out quite why he was wanting to come and see me, so having his blood pressure measured every four weeks. And for a while I almost sort of felt like we made up sort of medical reasons why that was required [...] I think a few of us have almost slightly guilty secrets about patients who come and see us every month and we kind of know it's not necessarily for a medical cause, and that I may not particularly share with my colleagues"

(GP5, male, urban, YOE: 5)

This theme shows the medical way in which GPs think about and manage loneliness, suggesting that they are constructing a medical problem from something which is inherently a social problem.

Whose responsibility is it?

There was some discussion regarding whose responsibility it is in managing and reducing loneliness in older people, whether it is down to the individual themselves or the wider society. There were some differences of opinion regarding whether

loneliness is something for which the responsibility should lie on the individual, versus it being something for which the GP is responsible for, much like any other medical problem. One GP suggested that lonely people who seek help from their GP may not necessarily take up what is offered to them, as those who are serious about reducing their loneliness will have already taken the necessary steps themselves: *"the people that are going to be up for it will have done it themselves"* (GP7, female, urban, YOE: 32). Another GP stated the importance of patients taking personal responsibility to help with their loneliness, again suggesting an individualistic viewpoint:

> *"I think that with a lot of things if you can get people to help themselves, and if it can be initiated by them… I would usually say "what do you think you could do?""*
> (GP2, female, urban, YOE: 1)

There was extensive discussion regarding the GP role with an issue like loneliness. There appeared to be conflicts of opinion about whether or not it was a GP's job to work with and manage loneliness, however also confusion and uncertainty within individual GPs. Some GPs felt strongly that loneliness was a social problem and that it was not a GP's role to deal with social issues that presented in general practice, but rather that is should be managed on an individualistic basis:

> *"It's a bit like benefits or housing or, you know, those range of social issues that people have that may not actually be something that a qualified doctor is best able to deal with"*
> (GP3, male, rural, YOE: 24)

> *"families can be more interactive in getting their lonely family member.. like they can do our job in a way, they can find them clubs to go to or direct them in different ways so that kind of avoids having to come*

through the GP really at all. And maybe offering them the reassurance
instead of through us"
(GP11, female, rural, YOE: 3)

Some GPs talked about loneliness as something that was a result of an individual's way of being and brought on by themselves, implying that loneliness is more of a personal and individual issue rather than something that is social and a product of wider cultural ideologies:

"Some people are possibly lonely because they're not very nice, you
know, they've never made any friends 'cause people don't want to talk to
them and they're reaping the benefits of that"
(GP6, male, urban, YOE: 26)

However, others felt that it was indeed a GP's role to work with social problems, as they could offer skills such as listening and supporting in the long-term, rather than simply focusing on being curative:

"there is a lot of your job that is a lot of actually listening and almost
kind of paying remiss or being somebody to hear about somebody's story
– that's a pretty important part of the job"
(GP5, male, urban, YOE: 5)

"I think one of the strengths of general practice is, and it's important that
it's not abused, but it's to support people as opposed to curing them"
(GP7, female, urban, YOE: 32)

The theme of 'A Western Approach' considers Western, neoliberalist ideas of medicalisation of loneliness, and individual responsibility of problems. GPs showed some conflict about whether loneliness was an issue that should be managed within or outside of general practice. There was also discrepancy between the idea of medicalising loneliness, while simultaneously arguing that it is a social issue and

should be treated as such, outside of medical general practice. These conflicts, sometimes within the same GP may reflect a wider incongruency in general practice between how GPs are trained and how they subsequently have to work and manage their patients.

3. <u>A DIFFICULT TOPIC TO TALK ABOUT</u>

This theme contains two sub-themes, and looks at GPs' barriers to addressing the issue of loneliness in general practice consultations, as well as the vicious cycle of stigma that pervades society, patients, and the GPs themselves.

GP barriers

The most commonly cited barrier for GPs addressing the topic of loneliness with their older adult patients was time. They felt that the consultation time limit of 10 minutes was too short to explore such issues in depth, and combined with the fact that they were often over-running with their daily appointments meant that they were less likely to ask about loneliness:

> *"if I'm running an hour late and I don't really have time to, you know, go*
> *into too much depth about these kind of issues – which I know is not an*
> *ideal situation at all, but unfortunately we've only got 10 minute*
> *appointments"*
> (GP4, female, urban, YOE: 1.5)

In relation to this, GPs also spoke about loneliness as "Pandora's Box", which would open up a lengthy avenue of conversation, which they may not have time for on a particular day:

> *"I suppose it's the Pandora's Box, opening up a can of worms as well,*
> *you know, you are time-pressured in consultations, and it depends on how*

well you know them, you might know a lot of this stuff already but if you don't and you start prying and it all comes out, then it's essential you deal with it and you deal with it properly"
(GP17, male, urban, YOE: 26)

GPs reported that some patients do not want to admit that they are lonely or may not wish to discuss it. Therefore even when GPs suspect that a patient may be lonely, the patient's resistance towards talking about it puts a barrier in place for the GP. For some GPs, the worry about how a patient will react to their questioning about loneliness acts as a barrier to asking in the first place:

"I think probably the biggest is the fear of causing upset"
(GP9, female, urban, YOE: 7)

"I think it's very important if somebody is in that group where they may be feeling quite lonely, you don't want to be rubbing salt in the wound"
(GP7 female, urban, YOE: 32)

However, there was some disagreement about this, with other GPs stating that in their experience patients did not tend to take offence to being asked about loneliness, and generally reacted well to it:

> ***I:*** *"How is that received then, when you ask quite bluntly?"*
>
> ***GP2:*** *"Pretty well to be honest, yeah. I mean I think people expect to have questions asked when they see the doctor. And people don't tend to take offence"*
> (GP2, female, urban, YOE: 1)

This highlights GPs' mixed experiences of raising the issue of loneliness with patients, but perhaps also the different perceptions and concerns that some GPs have which may act as a barrier to them asking their patients whether they are lonely.

The issue of cultural and language barriers was raised, particularly with GPs working in urban locations. One GP talked about how using interpreters would make him less likely to ask a patient more in-depth questions, such as regarding their loneliness:

> *I:*   *OK, so would that affect the likelihood of you maybe asking about things like isolation and loneliness?*
>
> *GP8:*   *Well it's going to affect it, but in a very negative way 'cause I won't ask.*
>
> *I:*   *Right, so less likely to ask.*
>
> *GP8:*   *Much less likely. Because you know, you've got to think about time and on average it will take twice the amount of time, twice the amount. And if somebody's coming in with three problems, you know it is not unknown for me to be spending 45 minutes with patient via an interpreter when I've been allotted 20 minutes. And that means everyone else outside is going to be complaining that they're waiting too long. Now what, just from my description there.. am I going to ask about loneliness? I'm not.*
>
> (GP8, male, urban, YOE: 29)

This barrier of a patient not speaking English ties in with the previously-mentioned barrier of time, as GPs felt that communicating with non-English speaking patients took a lot longer and therefore hindered them in exploring issues which they may have otherwise liked to.

Another common topic that arose as a barrier for GPs asking their patients about loneliness was the concern that they would not know how to help if a patient was indeed lonely:

"I think sometimes it does feel like we don't have, we don't have a lot to be able to contribute and that maybe does contribute to being a bit more hesitant to bringing up loneliness"
(GP9, female, urban, YOE: 7)

In conclusion, GP12 summarises the two mostly cited barriers which GPs repeatedly talked about in the interviews:

"Haven't really got the time and wouldn't really know what to do, I suppose is the real answer"
(GP12, male, rural, YOE: 25)

The vicious cycle of stigma

GPs reflected on the fact that being lonely has pejorative connotations and is somewhat stigmatised in our culture, and that the surrounding stigma may be a barrier to patients talking to their GP about it, or even admitting to themselves that they may be lonely:

"you get people who don't want to admit that they're lonely, that might feel that it's not something they want to be"
(GP6, male, urban, YOE: 26)

"So there's certainly lots of people out there who are lonely who just aren't telling us they're lonely, 'cause it's not maybe a socially acceptable thing to come and tell your GP about"
(GP14, female, rural, YOE: 18)

GPs also spoke about the indirect way in which loneliness is communicated between the patient and GP. It appears that patients rarely come into general practice and tell their GP outright that they are lonely, but that the GP will pick up on this through their behaviour, for example frequent attenders, not having any real physical problems, or attending for minor reasons:

> *"some patients will just come in quite a lot for minor things or for no apparent reason than have a chat. And so you kind of pick up on it from those kind of things. Or they come in with little physical problems which aren't.. there isn't really much going on and you kind of think, is it just that they need someone to talk to?"*
> (GP11, female, rural, YOE: 3)

It is evident that stigma around loneliness is an issue for patients in talking about it, however it appears that this stigma may then be being enforced by the GPs. For example, throughout the interviews it was also evident that GPs do not ask their patients directly about loneliness, but rather question in an indirect way, for example:

> *"you would tend to ask about support networks and contacts and how people spend their time and those kind of questions"*
> (GP9, female, urban, YOE: 7)

When asked about this, some GPs considered asking patients directly whether they were lonely was *"cruel"* (GP7, female, urban, YOE: 32) and *"not terribly effective"* (GP3, male, rural, YOE: 24). This suggests that GPs also believe that there is a shame surrounding being lonely and therefore are uncomfortable with asking about it directly. Unfortunately, this may serve to further compound the patients' feelings of stigma around their loneliness, thus creating a vicious cycle of stigma between patients and their GPs.

However, some GPs did reflect that participating in the study had made them consider their approach more, suggesting that not asking directly about loneliness is an unconscious acceptance of the societal stigma that is held on the topic:

> *"Um, I'm just trying to think if I've ever asked that. Um.. I'm not sure that I.. I certainly don't ask that question regularly. Um, I think it would be quite a good question to ask because that would really focus the*

patient on recognising that that is the issue, and you know, that somehow
or other we need to find ways of getting out there. So I think that would be
quite a good question to ask"
(GP10, female, urban, YOE: 27)

This theme suggests that patients and GPs both feel the social stigma underlying loneliness and therefore both tend to communicate about it in a very indirect way. A vicious cycle is then created whereby the patient feels ashamed to talk about it, the GP then does not ask directly because they feel that it is shameful for the patient, and these actions thereby further compound the shame and stigma of talking about loneliness. Unfortunately this means that conversations about loneliness in general practice perhaps do not happen as much as they need to.

4. GP AS HUMAN

This theme includes four sub-themes, and explores GPs' more vulnerable side, how their work affects them, and the ways in which they cope with this.

GP emotions

Many of the GPs spoke about the emotions they felt when working with loneliness in their older adult patients. These emotions included guilt, hopelessness, and sadness, however the mostly cited feeling was frustration. GPs tended to talk about feeling frustrated with regards to feeling like there is not much they can do for the patient: *"What can I do - that's the frustrating bit"* (GP8, male, urban, YOE: 29). One GP spoke about having a great deal of empathy for his patients and wishing to help with their suffering:

"I feel empathic towards them in the sense that I want to share that loneliness with them and make them feel that, you know, that's a feeling that perhaps halved and shared is less burdensome to them"
(GP17, male, urban, YOE: 26)

Powerlessness

A major theme throughout the GP interviews was powerlessness, and this was something that pervaded most of the GPs' narratives. In the face-to-face interviews, it was also perceptible in the GPs' body language and facial expressions. GPs spoke about feeling more capable with medical issues, but not knowing what they can do or how they can help with loneliness:

"you might know where to send somebody with chest pain, you work that out quite quickly, and you might, you know, work out your local hospital pathways and all those things. You may well not know what to do if you've established that somebody really is quite isolated, you might not know who to send them to"
(GP5, male, urban, YOE: 5)

One GP gave a poignant list of all things she felt incapable of doing for the patient, further highlighting the sense of powerlessness:

"you can't give them what they need, you can't bring back their spouse who's died, you can't give them a friendship group, you can't necessarily get them walking again so they're not housebound anymore… you can't force people to go to a daycentre if they don't want to"
(GP1, female, urban, YOE: 1.5)

There was a sense that even when GPs did know what to do and how to help their patients with regards to loneliness, they felt powerless in not being able to fully "fix" the problem:

"I guess it's one of those things as doctors you want to kind of fix things and make things better, and it's one of those areas where it's quite tricky to fix that sort of a problem"

(GP13, female, rural, YOE: 10)

"I think yes, it was very hard really, and I think what was hard was that it couldn't be completely addressed really"

(GP7, female, urban, YOE: 32)

The interviews showed that while GPs wanted to completely fix their patients' problems, that it was expected from them by others too. GP1 (female, urban, YOE: 1.5) stated that *"people expect their GP to be able to sort everything"*.

It was felt that when patients did not want to engage with the help offered by GPs, this further compounded GPs' feelings of powerlessness. This led to situations where GPs were able to find something they thought would help their patients, which would then get rejected by the patient, leading the GP to feel like they cannot fix it all over again:

"some people will look at that booklet and think, well I don't really want to sort of engage in that, and then it's not so easy to kind of solve that problem"

(GP13, female, rural, YOE: 10)

One GP spoke about the powerlessness that she felt within her role as a result of the changing GP role and the lack of the time GPs have to deal with patients' problems:

"the role and the abilities of GPs within our profession is changing too; we're working in a very over-stretched, under-resourced environment; many GPs describe their working day as 'firefighting', so you're always trying to deal with too many things so therefore you have to prioritise, you know, the most medically unwell or the most demanding cases, and so

maybe catching up with a slightly isolated patient, but even informal thing, might be always at the bottom of your to-do list. Even though you'd like to be able to offer that help, you may not be able to offer it because you're just so busy and you're struggling to meet everybody else's demands too"

(GP16, female, rural, YOE: 2)

GP stress and burnout

This theme addresses the impact on GPs of working with emotionally-charged issues such as loneliness. GPs spoke about the issue of professional burnout as directly related to the levels of distress they were working with in their practices. Some GPs admitted that that was why they worked part-time, and some spoke about the rise of early retirement in general practice as a result of this:

"And people leave, people you know, some people just don't stick it and they burn out and maybe that's because they haven't had the right support. Erm, people I think retiring earlier, maybe that's a reflection"

(GP6, male, urban, YOE: 26)

"One finds one's own way, and you know, I have to say, but I've known that for a long time – my own particular way is not to be working anywhere near full-time in the practice. 'Cause I wouldn't be able to do it, and I wouldn't be here now if I had"

(GP8, male, urban, YOE: 29)

Talking about loneliness within their patients prompted some GPs to reflect on the loneliness and isolation of GPs themselves, and whether the pressures of their work may lead some GPs to feel alone:

"there are single-handed doctors and one wonders about their isolation, especially in this field when you are doing sort of eight sessions a week"

(GP8, male, urban, YOE: 29)

"I think you can very strongly identify with that. I think you can feel some of the emotions of it, I think most people will have had periods where they might feel lonely, or they might feel a bit isolated"
(GP16, female, rural, YOE:2)

Despite GPs voicing that burnout, isolation, and physical and mental health consequences are common in GPs, there does not appear to be much support for GPs or their wellbeing. GPs gave examples of situations they had been through where they had felt unsupported, and lamented the fact that they did not feel there was enough time or funds to support GPs fully:

"It all takes time; it would be lovely to have a sort of debriefing session for an hour a week where you could just, you know, talk about stuff yeah, but how much would that cost? It's never going to happen, that's a fantasy world"
(GP10, female, urban, YOE: 27)

One GP reflected on the fact that if GPs are stressed and burned out from their job, they may be prioritising tasks and therefore be less inclined to talk to a patient about their loneliness:

"So I suppose that loneliness in patients is likely to be quite low down their list if they're feeling totally stressed out of their heads really"
(GP7, female, urban, YOE: 32)

This raises the question of how GPs can be expected to help support their lonely patients when they are not being supported themselves.

Self-protection

Following on from the above theme, the idea of self-protection as a coping mechanism for GPs came up in the interviews, both consciously and unconsciously. There was a culture of stoicism, an *"expectation that you carry on and get on with it"* (GP2, female, urban, YOE: 1), and *"broad shoulders, just get on with it, you know, it's fine"* (GP3, male, rural, YOE: 24). As a way of being stoic in the job and 'getting on with it', GPs reported that they had to learn to defend and detach from their feelings as the only way through it:

> *"Well in practice what happens is when you move onto the next patient and you just compartmentalise it and you have to distance yourself from it; you can't, you can't take all of that worry and misery onto your shoulders because that's not good for your own mental health. You have to have a professional detachment"*
> (GP10, female, urban, YOE: 27)

Another coping strategy GPs used was to recognise the limitations of their job and how much they could realistically do to help:

> *"I think er gaining an understanding of the limitations of medicine and one's practice is pretty important early on otherwise you get completely defeated"*
> (GP5, male, urban, YOE: 5)

GPs also communicated their self-protection on an unconscious level through the use of defences and avoidance of certain topics. For example, humour was used as a defence when discussing issues that are emotional or difficult to talk about. GPs also commonly avoided a particular question in the topic guide which explored their feelings and impact on emotions when consulting with an elderly patient who was lonely. GPs tended to avoid this question about their reactions either through laughter, avoiding the question altogether and talking about something else, or by

answering it briefly and then quickly moving onto solutions and what could be done for that patient:

> *"Yeah it is emotional, it is emotive as you say, but usually people just tell you a very matter-of-fact, you know, and you could say, I often say, well there are places in [area] or in your city where you can get Christmas lunches offered to people who haven't got any family, or Age Concern, we've got an Age Concern in one part of our city here, and they offer a lunch and it's a really lovely meal"*
> (GP15, male, urban, YOE: 29)

This theme explores GPs' culture of stoicism and methods of self-protection from the emotions which arise both from their patients and within themselves. Following on from the previous theme of GP wellbeing, it appears that GPs may use these self-protection coping mechanisms as a necessary response to a job which can elicit burnout and physical and mental health problems, largely without receiving any support for this.

5. A NEED FOR SYSTEMIC CHANGE

This theme includes two sub-themes and explores GPs' views on the current problems of how they work and the way the social issues are addressed within the NHS system. It also contains thoughts on suggestions for improving the current system for GPs working with loneliness.

GP support

GPs spoke about the current problems with support for GPs who are working with social problems like loneliness, within primary care. GPs expressed that they felt

there was a lack of training in loneliness at medical school, and that it was not taught as a priority or perhaps even in the correct context:

> *"I would say that there's very little; I trained about loneliness as part of a mental health problem. It's not something that I think is high on the agenda at medical schools"*
> (GP17, male, urban, YOE: 26)

As a result of this feeling, GPs openly discussed suggestions for improving the way in which they work with loneliness. One GPs suggested that GPs are not getting enough support for the issues which they work with daily, and that this lack of support is detrimental to their mental health:

> *"I'm currently involved in a project on stress and depression and anxiety in GPs, which is incredibly rife really – it's a massive issue. So I think the bottom line is GPs, for many many reasons, are not feeling supported"*
> (GP7, female, urban, YOE: 32)

GPs were vocal about the type of support they wanted to receive. One GP spoke about the need for both more information regarding what GPs can offer, but also support with how to begin to broach a topic like loneliness during the consultation:

> *"I guess it's both the educational one, so what resources there are, but also I guess a lot of it is consultation style, so how to bring it up in the consultation and, you know, how to address it sensitively etcetera"*
> (GP4, female, urban, YOE: 1.5)

There was also a sense that the emotional effects of such consultations on GPs were not addressed enough during training, and that this needed consideration for the future:

> *"I think that sort of counter-transference of emotion is important for people to recognise with training […] the sort of effect of consultations both on patients and doctors, has become a bit squeezed out, there seems*

to be a bit less scope in the training processes to talk about those things
really. So I think it probably needs strengthening at some point"
(GP18, male, urban, YOE: 20)

Most GPs were in agreement that more support and training was needed, either during initial GP training or throughout their working career. However, there was some disagreement about this, with one GP expressing that further training in loneliness would not be something that he would be interested in:

"do we need more training or resources for loneliness? I suspect we
wouldn't get much take-up on that [...] am I going to engage in loneliness
training or something? No, I'm not"
(GP3, male, urban, YOE: 24)

One GP wondered whether increasing the priority and frequency of asking about loneliness was key in better identifying and managing the issues for GPs:

"I don't think it's something that we routinely discuss with patients, so
maybe actually it should become routine that just as we screen people
with, sort of chronic health problems for depression, we should be asking
them, thinking about loneliness in the context of those sort of 'at risk'
groups I suppose"
(GP1, female, urban, YOE: 1.5)

This theme suggests that GPs feel that there is not enough training or support for them in order to feel confident in identifying and managing loneliness within consultations. They suggest a need for more training and resources, and to be supported to understand the emotional impact of this on them. It is evident that not all GPs agree that this is a need however, and there may be other factors which prevent GPs from wanting to take advantage of further support, such as lack of time, or the

belief that loneliness as a social problem is not something that should be managed by GPs.

The wider system

GPs also identified problems with how the current primary care system is set up to deal with social issues like loneliness, as well as giving suggestions for what they feel could be improved in order to help older adults who are lonely. GPs felt that *"there is relatively little to offer"* (GP7, female, urban, YOE: 32) in terms of services for loneliness, that they are *"not terribly well joined up at the moment, there's not a clear directory of services"* (GP14, female, rural, YOE: 18), and that services often do not run for very long before they get closed down:

> *"you hear about a service one year and the next year you reach for the leaflet about it and it's not functioning anymore because they're all so dependent on charitable funding"*
> (GP10, female, urban, YOE: 27)

One GP also identified the issue of patients from different countries and speaking different languages, and expressed the view that services are not well set up for people who do not speak English:

> *"if you're not born in this country and you don't speak brilliant English then the services we have got aren't really suitable for those sorts of people"*
> (GP1, female, urban, YOE: 1.5)

These issues contributed to GPs feeling unsure of where to refer lonely patients, and therefore powerless in their ability to help (as discussed in a previous theme).

However, the GPs also had plenty of ideas regarding improvements to the current system and the changes they would like to see. For example, the most frequently cited suggestion was the need to streamline the current system and to have one named person (examples given included care navigators, community support workers, social workers) who the GP could refer lonely patients on to, and who could then have the time and resources to help the patient with the most suitable interventions and solutions for them:

> *"having somebody who you can direct somebody to, like a community support worker, who then gives more up-to-date information about what's available locally, is probably the best option"*
> (GP9, female, urban, YOE: 7)

> *"so the idea will be that the GP can then refer the person on to the social prescribing co-ordinator who's got the time to then sit down with the person and spend some proper time with them, rather than just 10 minutes in a GP consultation is just not long enough, you know, to deal with all the problems properly. And then to direct these people to the right services that provide some follow-up as well"*
> (GP14, female, rural, YOE: 18)

The benefits of this would be that the professional being referred to would have more knowledge about and access to available resources, but that they would also have more time than the GP and could tailor solutions to the individual, and be able to provide follow-up. Many of the GPs also expressed a wish for more services being funded and available as they benefit their patients, but that there was also a better way of letting GPs know what exactly was available to refer to in their area:

> *"but just more stuff in the community really for people to be involved in. Because when I see patients involved in all these things, it's amazing and it makes such a difference"*

(GP11, female, rural, YOE: 3)

"I suppose the most important thing would be to know about all the things that are available locally"

(GP 9, female, urban, YOE: 7)

GPs spoke about the type of services that might be helpful and that they would like to see more of. For example, one GP spoke about the importance of services that are personable, community-based, and provide direct face-to-face human contact:

"I'd like there to be some kind of opportunity for people to network and to meet in the local community through channels that are different [...] but I think it's not just about, I think it's not just about having a helpline for someone you can phone; I think they're very good, things like SilverLine, I think it's more than that; it's face-to-face human contact – that could be in your home or in a formal place like in a meeting room, it could be one-to-one or in a group, it could be voluntary or service-led, but I think that human interaction face-to-face is really.. that's what missing in people's lives"

(GP16, female, rural, YOE: 2)

GPs felt that it was important to raise public awareness of loneliness as a problem by talking about it more and making it a more acceptable topic of conversation in society:

"I think loneliness should be talked about, as there are lots of people who do not speak about it"

(GP11, female, rural, YOE: 3)

"that profile of older lonely people needs to be raised, and the public awareness needs to be raised because we're all going in that direction; we're all going to get old"

(GP19, female, rural, YOE: 3)

This theme outlines the different problems and frustrations which GPs have with the current system to manage loneliness in older adult, as well as the solutions that they would like to see within GP training and continual professional development, primary care, the NHS, and within society's ideas and values.

CHAPTER 4: DISCUSSION

This chapter will focus on bringing together the different elements of this study and discussing in greater detail what was found. It will include a summary of the findings, and relate this to relevant theories and literature. The chapter will then examine implications of the study findings and what this research adds to the evidence base, leading into ideas for potential future research. The strengths and limitations of this study will be explored, focusing on what went well and what could have been done differently. Finally, the chapter will conclude with a reflective statement, focusing on the researcher's thoughts about their positioning in relation to the study and what was learned during this process.

Summary of findings

Loneliness is outside of our control

This theme incorporates GPs' constructs of loneliness as a phenomenon, and the sub-themes within it tell a story of an external locus of control regarding whether people can become lonely during their lifetime. In the sub-theme of 'More than just a physical state', GPs reject the notion that loneliness is the same as a physical state of social isolation, concurring with Killeen's (1998) ideas about this. Killeen emphasises the importance of choice in social isolation, and that this choice was key in whether it

was considered a good or a bad state. The GPs also talk about social isolation as being a personal choice and something which people may choose for themselves if they enjoy being alone, thereby having a sense of control over it. However, they make the distinction between this and a state of loneliness, which they describe as something that goes further than just being physically alone, and may not necessarily even involve being physically alone. This includes a feeling of a lack of a deeper human connection with somebody, and a lack of feeling genuinely supported and understood by another human being. GPs were therefore in agreement that it was not enough merely to have other people around in order to not feel lonely; but that somebody could also feel lonely when surrounded by others if they did not feel that the connections they have are of a good enough quality. The idea that loneliness is not just a physical state of being, and that to not be lonely one must rely on relational connections with other people, suggests that there is an element of this that is uncertain and outside of our control. If a non-lonely state relies partly on others, there is some semblance of it which will always be uncontrollable. It is important to note that one GP did hold the view that loneliness was purely a physical state of being, and although a minority, this demonstrates differences of opinion and constructions of the phenomenon of loneliness between GPs.

It is important to consider these GP views within the current climate amongst numerous media campaigns and loneliness being a high priority within the NHS. Many healthcare policies use the terms 'loneliness' and 'social isolation' interchangeably, and do not define them as potentially different and unique states (e.g. Department of Health, 2012; NHS Choices, 2015). Therefore, GPs' opinions regarding the difference between social isolation and loneliness is not something that

is merely informed by healthcare guidelines and policies which they may have come across, but rather a belief which they have cultivated from their experience as a GP, personal life experiences, and/or discussions with other people.

GPs discussed potential causal factors of loneliness, some of which are circumstantial and cannot be changed, leading to the view that loneliness can be outside of our control. For example, they discussed the issue of gender and described seeing more male lonely patients, who also may be more difficult to help than their female counterparts. GPs mentioned that people who come from different countries and are unable to speak the local language are more likely to be socially isolated due to their inability to communicate and form connections with others. The presence of mental health conditions and certain types of personality traits were also cited as factors which the GPs felt played a part in the likelihood of being lonely, again elements which are arguably difficult to change or control. There was a sense of life circumstances also playing a role in determining if and when a person might experience loneliness. For example, GPs described how spousal bereavement can trigger a feeling of a loss of role (e.g. husband/wife/caregiver) which can in turn rob a person of their sense of purpose, ultimately reinforcing their loneliness. Residential location was also felt to be a factor, echoing previous literature (Fischer, 1973; Scott, 1979), as rural GPs spoke about geographical isolation as a factor in loneliness, while urban GPs felt there was more available for older people in terms of services and the ability to travel due to more accessibility and transport options. One GP felt that the increasing pressure for GPs to hit goals and targets was making consultations more impersonal and less of a meaningful interaction, which may lead to further compounding the feelings of lonely patients. This is a factor obviously affecting GPs'

work and their relationships with their patients, and highlights the fact that even the GPs themselves may at times feel that loneliness management is outside of their control. This study focused on loneliness in older adults and throughout the interviews GPs were encouraged to think about their older adult patients. However, GPs voiced that it was not just older adults who they had noticed were experiencing loneliness, but in fact also children, young people, single parents, and those that have recently moved to a new area. They point out that these populations may not necessarily be highlighted as high risk groups, but that they can also experience loneliness, suggesting that loneliness cannot be controlled by age either.

GPs addressed the issue of what might be perpetuating loneliness within our society in the sub-theme 'Why are we a lonely society?'. There was a sense of a recent change within society, whereby technology has become more prevalent and is slowly replacing human interaction. There was also discussion about the idea that the last generation has seen a breakdown of the traditional nuclear family model. This is in accordance with the sociological theory postulating that the importance placed on family life has been lessened by the decrease in traditionalism and increase in individualism (Gillies, 2003). Theorists argue that over time this has reduced people's value of social cohesion, as we move towards an increasingly individualistic society. There was also a sense that older adults and the issues that affect older adults are not as 'fashionable' or relevant in our society, which is becoming more and more angled towards being young and sociable, and as that as a result we are turning our backs on it as a whole. These wider societal forces again arguably feel as though something that cannot be controlled, and GPs certainly felt as though issues affecting older adults were not a priority within our society and culture at present.

This theme discussed GPs' constructs of loneliness and the external locus of control that can surround it. If loneliness feels outside of people's control, this then raises the question of how much do they then feel empowered or disempowered to take action against it. This feeling of being out of control in terms of who becomes lonely and how easy it is to prevent appears to pervade not only the individual, but also the wider society and the GPs themselves. When compared to traditional medical conditions which the GPs know how to treat and may feel in greater control of, loneliness may seem like something which is unpredictable and uncontrollable, and therefore may feel like a more difficult problem to tackle, or perhaps even impossible. The consequences of how this may then affect how GPs work with loneliness will be discussed later in other themes. This idea of locus of control did not come up in other literature about social problems within primary care, and may therefore further shed light on how GPs construct and think about an issue like loneliness.

A westernised approach

This theme highlights the predominantly Western values which underpin our healthcare system, and subsequently the way in which GPs work with loneliness. It covers ideas such as favouring a diagnostic, curative system over a preventive one, medicalising social issues, and a discussion about whose responsibility loneliness is on a wider scale – the individual's, society's, or the GP's?

The sub-theme 'A curative system', suggests that GPs view their role within our healthcare system as diagnostic and treating of illness. In the case of loneliness, GPs spoke about diagnosing and managing the physical and psychological effects of

loneliness (e.g. low mood), rather than preventing these problems by noticing and managing the underlying cause. Therefore, if GPs only address loneliness when it becomes something medical or 'treatable', this may perhaps be a reason why patients communicate their loneliness indirectly to GPs, in the form of other problems which may be seen as more acceptable and something which the GPs will be more predisposed to 'treat' (patient indirect communication is further discussed in 'The vicious cycle of stigma'). This reflects a wider theme in our culture of valuing diagnosis and cures over prevention. For example the use of the DSM-V pervades the very essence of how mental health conditions are viewed, talked about, diagnosed, and treated within our healthcare system. An individual needs to have a certain number of symptoms in order to fit a certain category of the DSM-V in order to be officially diagnosed with a mental health condition, and subsequently receive treatment for that condition. Furthermore, access to services works in a highly diagnostic way, continually raising the bar for how 'severe' individuals need to be in order to be helped. For example, measures such as the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) and Generalized Anxiety Disorder questionnaire (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) identify the extent to which an individual is depressed or anxious, and in turn how much they need help from secondary care psychological services as a result. This is often also accompanied by the need for suicidal thoughts and intent in order to be deemed 'severe' enough for referral to secondary care mental health services. Another example is not prioritising mental health and wellbeing earlier on in life during school years, but rather waiting for individuals to become 'unwell enough' to be diagnosed and then helped as a result. These examples suggest that as a society we seem to be concerned with identifying and fixing, rather than preventing problems before they

occur, and this is something that was reflected in the views of GPs when considering how they view and manage loneliness within primary care. This is in conflict with the government's initiative to reduce loneliness through prevention rather than cure (Department of Health, 2006), and suggests that perhaps this is not something that can change overnight as it is something that is deeply embedded within our society and culture, and something that may need to change over time.

The idea of a curative system is further compounded by GPs' medicalisation of a social issue like loneliness, through their language and the way in which they conceptualise it. For example, GPs used medical words such as "assessment" and "refer" when talking about loneliness. This suggests that GPs view problems through a medical lens, which can subscribe to a more positivist philosophical standpoint, believing that there is one truth and that it can be found if searched for through assessment, and treated by referral. GPs talked about the fact that this may come from their medical training, and that they are taught to primarily focus on the medical issues that arise, meaning that GPs may therefore be likely to medicalise any problem, even social ones like loneliness. This corresponds with the traditional training of medical schools which subscribe to the Western approach of using a medical model. This model suggests that problems have symptoms, which can be identified and treated (Shah & Mountain, 2007), and is the way in which many GPs work. However, this can be restrictive, and GPs admitted that their work can be limited by the restrictions of general practice and the medical model. This suggests that GPs may find problems which are more social in nature more difficult to work with, and may find themselves medicalising more and more problems. There is evidently a conflict between the more medical way in which GPs are trained to

construct and manage issues, and the various different types of problems which they then face in reality. It is important to note that with the increase of social problems, many GPs are working more holistically in their practice (RCGP, 2015), however is it evident that medicalisation of problems is still ongoing (e.g. McPherson et al., 2014) and something which is retained from the primarily medical model used in medical training.

The sub-theme of 'Whose responsibility is it?' encapsulates the ongoing debate of who should be held responsible for, and ultimately manage, the issue of loneliness in our society. GPs held a variety of different views on this, showing some disparity and incongruence of opinion. Some GPs held the view that the lonely individuals themselves could be the only ones who could help themselves, perhaps reflecting a wider culture of individualism consistent with more Western views, in contrast with Eastern views of the importance of community and support from others. There was some conflict between GPs regarding whether or not they considered managing loneliness as part of their role. Some GPs considered listening to patients and supporting, rather than curing, a pivotal part of their role, but others did not think that social problems such as loneliness were within their remit as a medical doctor. In some interviews, both opinions came up for the same GP, suggesting that even individual GPs themselves have not made up their mind on this issue. This highlights an incongruency between the way in which GPs medicalise loneliness, but then reject it as they consider it to be a social problem. This may reflect the wider inconsistency in the ways that GPs are trained, and the ways in which they subsequently have to work in general practice. For example, GPs are trained in highly medicalised language and in thinking of issues in terms of problems that can be identified and

treated. However, in reality GPs are faced with a wide variety of problems, including social issues, which may not necessarily be a medical issue, cannot be 'diagnosed' in the traditional sense, and may not have an easy intervention that a patient can be referred to, as is sometimes the case with loneliness. This incongruence between training and working may be confusing for GPs, and this is certainly evident in the conflict regarding social problems and the remit of the GP role.

Considering the fact that GPs are time-constrained in their consultations, yet continue to be faced with patients whose underlying root problem may be loneliness, this raises the question of whose role is it to identify and deal with loneliness in our society. Loneliness is deemed a social problem, however is increasingly being seen in medical settings. As previously discussed, a GPs' frontline role is to identify a general problem with a patient and refer onto specialist services if necessary. However, it is evident from the GP interviews that there has been a blurring of boundaries when it comes to identification and management of loneliness: GPs appear to be expected to know how to identify and manage loneliness (and without necessarily much training on this). In the interviews GPs were conflicted as to how much of this was their role. Some GPs felt strongly that management of loneliness was not their role and that this was something that needed to be managed by society and the individuals themselves, whilst others believed it was indeed part of their role listen and support their lonely patients. This perhaps reflects a wider uncertainty and 'not knowing' in our society about whose role it is to identify and manage loneliness. There is a stigma attachment to loneliness (which will be discussed in a later chapter: A Difficult Topic To Talk About), and the embarrassment and anxiety that comes with this may be one reason why people do not speak about loneliness within

communities and societies. Instead people seem to feel more comfortable communicating their loneliness as part of a medical problem, which then becomes the role of their GP. Therefore, it seems that whilst loneliness continues to be indirectly communicated by being entangled with physical problems, it will continue to appear within primary care. This further raises the fact that we firstly need to de-stigmatise loneliness as a wider society in order for it to become more acceptable to talk about, and therefore shift the responsibility from the GPs to communities, in order for a social problem like loneliness to truly be the responsibility of society itself.

In summary, this theme discusses GPs' views on how a social problem like loneliness should be viewed and managed within general practice. GPs largely held Western, individualistic ideas regarding the importance of individual responsibility over community and society. Furthermore, GPs display preference to more Westernised, medical approaches, working in a more medical-model curative way, seeking to resolve problems once they are showing symptoms, rather than preventing problems from arising in the first place. This is arguably a product of the Western, individualistic culture we live in and the corresponding values that we live by, which suggests that this theme may be more synonymous with Western countries, and that GPs in other more Eastern cultures may hold different views. This theme also encapsulated GPs' disparity of views regarding their role in relation to a social problem like loneliness, and this incongruence perhaps reflects a wider conflict between GPs' training and the types of problems which are they are being faced with in current general practice.

A difficult topic to talk about

This over-arching theme considers why loneliness may be a difficult topic to talk about between GPs and their patients. It contains two sub-themes, one of which includes the various barriers which GPs face when it comes to talking about and addressing loneliness in their practice, and the second which looks at the stigma that surrounds this phenomenon and how that can create challenges in talking about loneliness on an individual basis, but also on a wider societal scale.

The sub-theme of 'GP barriers' considers the individual challenges that GPs face when it comes to talking about and addressing loneliness with their older adult patients. GPs emphasised the barriers of having limited time for their consultations, usually about 10 minutes, and that this did not provide them with enough scope for dealing with what might arise if they asked a patient about loneliness. GPs termed it as opening "Pandora's Box", as they did not know what would arise from asking the question and how long the conversation would subsequently last. This barrier echoes that found by van der Zwet and colleagues (2009), who also present a perceived lack of time to be a challenge faced by GPs when working with loneliness. Related to this, GPs said that the use of interpreters with non English-speaking patients took up further time due to the practicalities of interpreting conversation back-and-forth. Therefore, GPs said that they would be less likely to ask about loneliness in a consultation with an interpretor, as this would be likely to extend the conversation even further and thereby put even more pressure on their time constraints. This clearly puts non English-speaking patients at a disadvantage as they are less likely to be asked about loneliness. Unfortunately, as seen in the previous theme of 'Some people are more likely to be lonely than others', they are also a group that is more

likely to be at risk of loneliness due to potential isolation caused by the inability to speak the local language and communicate with others outside of their immediate language group. The barrier of time constraints is therefore a very pervasive challenge which GPs face in regards to bringing up loneliness in their consultations.

GPs also talked about their worry about the patient's reaction if they asked them whether they were lonely. GPs were very aware of the potential to cause offence to the patient by asking this question, and considered it as possibly 'rubbing salt in the wound' and making the patient feel worse. However, other GPs stated that they received positive reactions from their patients, and that concern about patients' reactions was not a barrier for them, suggesting mixed reactions from patients. This might also reflect a disparity between different GPs' preconceptions of loneliness and whether it is something that is socially embarrassing and might as a result cause social upset or distress if talked about. This finding mirrors previous literature, as van Ravesteijn et al (2008) found that GPs reported a variety of mixed reactions from their patients when the issue of loneliness was brought up, including anger, frustration and denial, but sometimes also relief and alleviation from pain, again showing different experiences by different GPs. This may suggest that asking about loneliness can be a self-fulfilling prophecy, in the sense that if a GP considers it an embarrassing topic to talk about, this feeling is then portrayed in the way they talk about it with their patients, who then also feel as though it should be embarrassing or upsetting, and therefore display those feelings in their reactions. Conversely, if a GP does not consider loneliness as something embarrassing to talk about, they may ask about it more confidently and thereby transfer the notion to their patient that

loneliness is acceptable to talk about, and the patient may feel more relaxed about it as a result.

Finally, GPs cited the fact that they do not always know what to do about a patient's loneliness as a barrier, and that this feeling of uncertainty prevented them from breaching the topic in the first place. This links to the theme of 'Powerlessness' (discussed later), in which GPs note that they tend to feel as though they cannot do much to help or 'fix' the problem of loneliness. In this case, it is evident that if an issue is not immediately soluble or 'fixable', then that will be a barrier for GPs in bringing it up with their patients, as they do not wish to face these feelings of powerlessness and inability to help.

The sub-theme of 'The vicious cycle of stigma' focuses on the stigmatisation of loneliness within our culture, society, and consequently individuals, and how this impacts on the exchange between GPs and their older adult patients when it comes to discussing loneliness. GPs showed awareness of the stigma in society that surrounds loneliness, and they felt that patients did not want to talk about it with them due to a fear of it being shameful or not socially acceptable. They noted that patients would often communicate their distress or needs through indirect ways, for example by presenting to their GP with repeated minor physical complaints, or asking for examinations which they do not need. This suggests that as a society we may feel more comfortable about admitting to and talking about physical problems rather than emotional and social ones, such as loneliness, which are more stigmatised. This may also be the case in medically unexplained symptoms (MUS), in which patients' emotional difficulties sometimes manifest as physical symptoms, which are easier to

talk to doctors about, diagnose, and treat (e.g. Jutel, 2010). Alternatively, older adult patients may hold more traditional views of their GP as a medical doctor who only treats physical ailments, and not feel as though they can talk to them about feeling lonely. This view is highlighted in a recent study showing that older people do not believe that their GP can help with their loneliness as it is not a physical illness (Kharicha, Iliffe, Manthorpe, Chew-Graham, Cattan, Goodman, Kirby-Barr, Whitehouse, & Walters, 2017).

Interestingly, it was also evident from the interviews that GPs similarly breached the topic of loneliness in an indirect way, either through asking indirect questions about activities, friends, and family, or by allowing the patient to bring the topic up first. GPs' reluctant views on talking about loneliness more directly has been demonstrated in previous literature (McPherson et al., 2014), and suggests that GPs also have a held belief that there is something socially embarrassing or shameful about being lonely and admitting to being lonely. Thereby, by GPs dealing with loneliness in a largely indirect way, they are confirming the cultural message that loneliness is something that is not socially acceptable to talk about openly, and further compounding this view that the patient might hold, creating a vicious cycle of stigma that continues to circulate in our society. This finding mirrors a similar finding by van Ravesteijn et al. (2008) who also noted that patients and GPs both tend to approach the topic of loneliness in an indirect manner. The question that is raised here therefore, is if both the patient and GP are failing to be open and upfront about the issue of loneliness, then how long will the indirect communication need to last until the topic is properly addressed? If lonely patients are frequently seeing their GP but their underlying

reason is not being addressed, this will arguably have an impact on primary care costs and resources, as well as the patients' wellbeing.

The maintenance of the stigmatisation and shame that surrounds loneliness can be linked to Bandura's (1977) social learning theory, which postulates that people learn from each other by observing and copying behaviour. Therefore, if a behaviour such as stigmatisation is observed in others, then it is likely to be imitated and retained. Furthermore, if key respected members of a society (such as GPs) are also showing these views and behaviours, then people are even more likely to respect their opinion and therefore imitate the social behaviour. This is illustrated by a study showing the influential effect that GP influence can have on patient smoking cessation (Russell, Wilson, Taylor, & Baker, 1979). However, it is important to note that this is an unconscious process and that GPs are not deliberately suggesting that loneliness is embarrassing or shameful. This is illustrated by the fact that several GPs stated that their participation in this study had caused them to reflect on why they do not ask about loneliness more directly, and considered being more aware in their practice as a result.

GP as human

This theme considers the other side of GPs that is not usually seen, comprising the emotions and vulnerabilities of their role when working with social problems like loneliness. Although some were slightly reluctant to talk about themselves and their emotions, most GPs did discuss feeling emotions like sadness, guilt, and frustration when working with loneliness. The frustration they felt was usually a result of feeling as though there was not much that they could do to help, linking in with the second

sub-theme of powerlessness. This finding corroborates the findings from other literature in the field, which also found that GPs feel powerless and frustrated when working with loneliness (van der Zwet et al., 2009). Furthermore, GPs discussed feeling empathy for their lonely patients, and genuinely wanting to share their burden and lessen their distress. A systematic review found that GP empathy for their patients was associated with decreased patient anxiety and distress, improved clinical outcomes, and that patients felt more enabled as a whole (Derksen, Bensing, & Lagro-Janssen, 2013), suggesting that GP empathy is an important skill in general practice.

Following on from this, another sub-theme was the idea of 'Powerlessness', which ran throughout the interviews with GPs and pervaded much of their narrative about loneliness. There was a sense that GPs were not entirely sure how to help with social issues like loneliness. This particularly came through in a quote in which a GP compared knowing where to refer a patient with chest pain, but not knowing what to do with a patient who was lonely. This suggests a disparity between the medicalisation of loneliness with regards to how GPs conceptualise and diagnose it (discussed above), and then the seemingly different way in which they manage it. Using the current example, GPs may know how to refer to a specialist clinic for a physical condition as they have researched this, but it appears to be more difficult to know how to manage or where to refer to for a social issue like loneliness. This may be to do with the fact that GPs are trained in a largely solution-focused, practical way in diagnosing and treating physical ailments, and they may therefore still hold this way of working in which all problems can be approached and solved in the same medicalised manner. For example, all problems should have a clear pathway and

directory for referrals. However, this is not the case with all problems, especially social issues like loneliness; diagnosis and referral is not as clear-cut as it would be for chest pain, and this 'messier' style of working may not be something that GPs are comfortable with, or even trained to do. Indeed, this concurs with Shah and Harris's (1997) suggestion that GPs feel less confident using their diagnostic skills when working with social problems, which may be due to the fact that the same skills used for medical conditions may not necessarily be the same skills required for social problems. The issue is that working with clear-cut physical symptoms and loneliness are two different problems, and require two different ways of working. If GPs are used to only working in one clear-cut type of approach, then they may undoubtedly feel powerless when faced with something that is not easily 'diagnosed' and does not have a clear referral pathway for 'treatment', and in fact may not even necessarily be able to be treated.

This idea of patients rejecting GPs' suggestions of solutions also came up in the interviews, suggesting that GPs are used to patients complying with medical treatment, and therefore not knowing how to manage the resulting feeling of powerlessness when a patient does not wish to engage with the proposed solutions. The sense of frustration and powerlessness seems to come from an idea that loneliness is 'unfixable' and will take up lots of GP time, compared to medical problems which are seen as soluble and can be solved quickly, further compounding the medicalised view that some GPs hold about loneliness. Moreover, this pessimistic way of viewing social problems may cause a vicious cycle in which GPs feel negative emotions such as frustration and powerlessness when faced with a social problem, which then may in turn affect their consultation with the patient and how they manage

the problem, and over time influence their views and feelings towards working with that social issue.

The idea of GPs feeling powerless because they are not fully able to fix the problem of loneliness not only highlights their medicalised and solution-focused training, but also the fact that this may affect their identity as a doctor whose role is to help people and fix problems (social identity theory; Tajfel & Turner, 1979). The GPs spoke about how they view their role, and much of the narrative was about diagnosing, treating, and fixing of problems. However, it is evident that when faced with a problem like loneliness, there are no clear guidelines for diagnosis or treatment, GPs feel as though they do not know how to manage the issue, and at times patients are rejecting of potential solutions and may not even be aware that loneliness is an underlying cause of their problems. Therefore, if GPs are not able to fully 'solve' a patient's loneliness (which may be much of the time), their professional, and potentially personal, identity is at risk, and they may feel that if they cannot fix a problem then they no longer have a role. This is potentially an important finding, as it may be part of the reason why GPs do not like working with social problems, and may go some way to explain the stress that GPs feel they are under when working with a social problem like loneliness (see below).

Following on from the above, GPs spoke openly about the impact on themselves of working with social problems, and the resultant stress and burnout that they feel is rife in the GP profession as a result. GPs spoke about the professional burnout that can arise from working with emotionally-charged problems such as loneliness, and GPs felt that this was a large reason why GPs are increasingly leaving the profession

and retiring early. Some of the interviewed GPs only worked in general practice part-time, and talked about the fact that this choice was a way of coping and managing the emotional impact of working with social problems like loneliness. One GP was candid about the fact that this resultant stress and emotional impact on GPs can affect their work in the sense that they are more likely to prioritise particular patients, and that issues like loneliness may get left behind as a result. This is in line with studies which highlight the negative effects on GPs when working with social problems, such as feelings of lack of time (Zantinge et al., 2005) and lack of confidence (Shah & Harris, 1997). Furthermore, GPs suggested that working with loneliness may cause GPs to reflect on their own relationships and feelings of loneliness, which may impact on them emotionally. It is clear that general practice is seeing an increase of social problems, and it appears that GPs are feeling negatively impacted by this in terms of increased stress and burnout. However, GPs also stated that they do not feel as though there is enough support for them to deal with the emotional impact of working with social problems. GPs gave examples of times when they ironically felt very alone when dealing with issues that they felt were outside of their remit. GPs felt as though a debrief session for difficult cases would be useful, however were cynical about this becoming a reality due to the lack of time and money. GPs offered some ideas and solutions that they would find helpful, which will be discussed in more depth in the theme of 'A need for systemic change'.

It was interesting to note in the interview reflections that GPs were sometimes avoidant in talking about their emotions and the impact their work had on them personally. This may suggest a certain stoicism which is necessary when working with people who are unwell, but also perhaps a separation of their "non-GP self" from

their "professional self". This may be a method of self-preservation and self-protection which GPs unconsciously use to protect themselves from the emotional burden and stress which they encounter daily, and may not necessarily have the extent of training to deal with it as other professions might (e.g. psychologists). GPs expressed their views of needing to *"just get on with it", "carry on and get on with it",* perhaps reflecting wider westernised capitalist culture, both in medical schools and our general society, in which failure and setbacks are not necessarily tolerated. While this can act as a self-protection mechanism, this can arguably cause suppression of emotions and difficulties in the long-term. Furthermore, this ideology may clash with the way in which lonely patients present to GPs, potentially leading to a lack of patience and/or empathy. GPs also presented the importance of distancing themselves from their emotions as a way of coping with the emotional burden of working with loneliness, and in fact viewed this as a professional skill. This is in contrast to other healthcare professionals who work with emotional issues, such as psychologists, who often belief that the opposite is true, and that being aware and in touch with emotions that a patient can elicit is a crucial part of the job. Interestingly, GPs discussed being aware of the limitations of medicine and of what they can realistically do, as a method of self-protection. This contrasts with their views of needing to be able to fix all of their patients' problems, again highlighting some conflict in opinion.

This theme presented some differences amongst GPs were recently qualified and those who had had more years of experience (YOE). Whilst most GPs spoke about the feeling of powerlessness when working with loneliness in older adults in some way, GPs with less YOE spoke about this more and it was certaintly evident when

conducting interviews with them. GPs with less YOE also spoke more about stress and burnout in their jobs. This difference may reflect the development of self-protection strageies and professional detachment seen more in GPs with greater YOEs, and as a result they may be less likely to be susceptible to the emotional pressures of their job.

The theme of 'GP as human' shows a more personal side of the GP, and the ways in which they cope with and manage their resulting feelings and effects of working with loneliness. It is evident that GPs are affected by their lonely patients, in terms of personal emotions and work-related stress, and that they manage this through the use of self-protective coping strategies which may have been influenced by the culture of medical training, and also our wider society's values and ideals.

A need for systemic change

This theme focuses on the problems that GPs see in the current primary care system with regards to social problems like loneliness, and considerations of what could be improved for the GPs themselves and for the wider system as a whole. Within the sub-theme of 'GP support', GPs discussed the shortcomings in terms of being individually supported and the changes they would like to see in GP training and ongoing professional development. There was a sense that loneliness is taught minimally, grouped together with mental health problems, and is a low priority within medical school agendas. Although the GP training curriculum does show training in holistic, biopsychosocial working (RCGP, 2015), it is evident from GPs' accounts that this is not necessarily the case when it comes to understanding loneliness, and that loneliness is instead treated as psychological, rather than also understanding the

social factors connected to it. GPs also spoke about not feeling adequately supported in terms of their emotional reactions to social problems like loneliness, possibly leading to a rise in GP anxiety and depression. These ideas echo those of the GPs which Taft and colleagues (2004) interviewed, who also felt a lack of support and supervision in relation to their work with partner violence and domestic abuse. GPs voiced that they would like to see further teaching in medical schools and post-qualification support being offered, in the form of education about loneliness, consultation style and how to sensitively conduct a consultation around a social issue such as loneliness, as well as receiving more support regarding their emotional reactions to the work and the counter-transference that is felt in the room. However, there was also disagreement with these ideas, and some GPs felt that further training and support for working with social issues like loneliness was not required, and was not something that they were likely to engage in.

In the sub-theme of 'The wider system', GPs spoke about the problems with how loneliness is currently addressed and managed within the healthcare system, and how this affects the GPs and consequently patient care. They also provide ideas for wider system improvements and changes that they would find more useful when working with loneliness in older adults. GPs felt quite strongly that there were very few places to which they could signpost or refer lonely patients and that there were restricted in options for services. They felt that the directory of services that was available to them was unclear and made it difficult for GPs to know exactly what services were available where and when. Furthermore, GPs noted that even when they knew about potential services, those organisations tended to be transient and did not stay open for long due to difficulties with securing continual funding. These findings are consistent

with those of McCall-Hosenfeld et al. (2014) and van der Zwet et al. (2009), in whose studies GPs also discuss limited referral options as a problem in the healthcare system. These studies were carried out in the USA and the Netherlands respectively, indicating that this problem is not UK-specific and that limited referral options for social problems are also an issue in international health and social systems. Additionally, GPs suggested that services for loneliness are not well set up for people who do not speak English, and that there may be limited options for this group of people. Unfortunately, as discussed previously, non English-speaking populations are more likely to be lonely in the UK, and therefore in greatest need of services, which are evidently not widely available to them.

GPs offered suggestions for improvements in the current primary care system to aid management of loneliness. There was a sense that the current signposting system was unclear to GPs and they wanted a more streamlined system, in which they could refer lonely patients to a specific named person (e.g. care navigator, social worker). This professional would then be responsible for the management of the patient, and would be better able to offer the time and resources to tailor the most appropriate solution to the patient. This echoes thoughts from Jego et al.'s (2016) study, in which GPs felt that working with other professionals, such as social workers, would enhance their ability to be able to care for and offer interventions for homeless patients. There is indeed research presently underway at University College London which is developing a community navigator intervention aimed to reduce loneliness in the community (Lloyd-Evans, Bone, Pinfold, Lewis, Billing, Frerichs, Fullarton, Jones, & Johnson, 2017), suggesting that this is an important area to look at in terms of loneliness, and that alternative methods need to be considered beyond solely GP

signposting. GPs also spoke about the fact that it was not enough to provide surface-level interactions, but instead emphasised the need for more personable and face-to-face contact, compounding the previously discussed idea that loneliness is more than just being physically isolated, but a lack of real quality human connection with others. GPs were also aware of the fact that loneliness is not regarded as something that is socially acceptable to talk about, particularly in older generations, and that there is a need to raise public awareness of the issue and for it to be talked about more in our society. Loneliness has indeed been a topic of interest within the media recently, sparking campaigns by the Co-Operative and British Red Cross, as well as the Campaign to End Loneliness, suggesting that loneliness is widespread in our society and therefore important to talk about.

In summary, the findings of this thesis show the westernised, medical angle from which GPs view and manage the issue of loneliness, discuss the barriers which can stop GPs and patients from talking about loneliness in consultations, display the effect that working with loneliness can have on GPs, and highlight some of the shortcomings of the current primary care system and what can be put in place to improve provision for lonely patients. The findings also highlight the conflict of opinion between GPs, and sometimes individual GP themselves, perhaps reflecting the wider disparity between the way in which GPs are trained and the way in which they subsequently have to work. It is evident that GPs are facing increasing levels of social problems in their practice, however are not fully equipped to manage this in terms of the way in which they are trained and supported as they go through their career.

Implications

This section will focus on eliciting learning from the findings above, and providing ideas for how this research can usefully inform the way in which loneliness is managed in primary care. It will explore implications from the angle of GP training and support, clinical implications for management of loneliness, the wider views that we hold as a society, and how future research can extend the work of this topic.

GP training and ongoing support

GPs' accounts of how loneliness is taught in medical schools suggest that it is presented alongside mental health rather than being considered as a social problem. Furthermore, GPs approach the issue of loneliness in a medicalised way, and although this is understandably a necessary way of learning and practising medicine, it can perhaps be a hindrance when it comes to GPs facing ever-increasing social problems within primary care. As seen from the findings, GPs are taught to approach problems in a largely systematic fashion; to diagnose, treat, and refer. However, this approach does not always work with social problems and issues which cannot be medicalised or necessarily even 'fixed', and as a result GPs may feel powerless, less confident in their ability to help, and perhaps even avoid these issues altogether for fear of opening "Pandora's Box" and then not being able to help with it. There is clearly a discrepancy between the way in which GPs are trained and how they then work with social problems. This suggests that there is a need for greater emphasis on teaching about social problems, such as loneliness. As the findings show, GPs would appreciate more knowledge and education about loneliness, more training on consultation style and how to talk about the issue, and consideration of GPs' own emotional responses to patients' loneliness and how they can best manage them.

Moreover, medical schools may benefit from a cultural shift in terms of the medical message that is portrayed to students suggesting that there is a solution for all problems. This is not necessarily a conscious message, however it is evident from the way the GPs spoke about loneliness that there is a culture and belief that everything is, or should be, soluble. GPs-in-training may perhaps benefit from an alternative idea that not every problem they see in primary care is necessarily 'fixable' and how to manage their own feelings regarding this idea. This is especially important as primary care sees a rise in patients presenting with social problems (The King's Fund, 2016).

In relation to this, GPs felt that they would benefit from ongoing post-qualification support in the form of further training on social issues that they are not familiar with, the option to debrief with an individual or group about patients they are finding difficult to work with, and an outlet for their own emotional reactions to patients and their work. The findings show that GPs are feeling unsupported, but simultaneously hold a "keep calm and carry on"-type view that is particularly prevalent in the medical profession, and therefore do not voice this need for further support. The lack of time is another barrier for this, but it can be argued that by allocating some time specifically for GP wellbeing and emotional support, that this will help with GPs' stress and burnout in the long-term, and in fact keep GPs working effectively in their roles for longer. Furthermore, psychoanalytic theory purports that transference and counter-transference (e.g. Arundale, 2011) often comes into play between patient and doctor, and are important elements to consider in therapeutic interactions. GPs may find that they feel particular emotions after seeing certain patients, however if there was a dedicated space where they could reflect on these emotions, they may feel better equipped to notice these transferences and manage them in their work. This can

perhaps be explored through the use of monthly GP reflective groups (similar to Balint groups; Salinsky, 2009), or protected individual sessions with a senior clinician.

It is important to note the changes over recent years regarding the way GPs are trained. There has been greater emphasis on holistic training and implementation of reflective practice. These changes can be seen somewhat in the differences of opinion between recently-qualified GPs and those who have been working for a longer period of time. For example, GPs with shorter YOE expressed a greater need for more GP support in terms of training in consultation style and having a space to debrief after difficult cases. This may be a product of recently-qualified GPs having been exposed to more holistic training programmes and therefore wishing to continue with this in their qualified roles. On the other hand, GPs with more YOE tended to be more 'stoic' in this respect and reject ideas of further training for loneliness. This may be to do with when they trained as GP programmes tended to be more 'medicalised' than they are now.

Clinical implications

GPs cited a lack of appropriate referral options and an unclear referral system as a barrier to addressing loneliness with their patients. This calls for more joined up working between medical and social care. In practice, this could be done by community services having a clear and up-to-date directory of services, as well as a more streamlined approach which GPs can follow to find out which services are available in their area. It is evident that GPs are hindered in helping lonely patients

because it takes more time than they have available. GPs have suggested that streamlining the process for loneliness in primary care would be helpful, perhaps by having a specific named professional who the GP can refer lonely patients to. This person could work for all the surgeries in the Trust or borough, and can allocate more time to provide services for lonely patients, for example getting to know the person and their specific needs, signposting them to appropriate services, and helping more reserved patients by attending an activity with them for the first time. These tasks would alleviate the time pressure from GPs and would be greatly beneficial to lonely patients. These suggestions regarding service changes are especially important at this time due to recent changes in how services are funded and GPs' greater involvement in commissioning and funding of services. It is therefore crucial to raise awareness of the need for service and system changes for social problems amongst practising GPs who have influence over these decisions.

The issue of a lack of services for non English-speaking patients was also raised. Considering that this population of people is likely to be in need of services for loneliness, there needs to be more consideration of provisions for people who speak other languages or come from different cultures. These provisions could include culture-specific social groups, use of translated leaflets and advertising materials for services, or social prescribing for English lessons in order to encourage integration.

The findings of this study suggest that GPs largely adopt a curative, rather than preventive, approach to their work, and this is also the case with social problems like loneliness. Unfortunately, the result of this is that lonely patients tend to present repeatedly to primary care. Furthermore, the negative physical, psychological, and

lifestyle effects of loneliness, which have previously been discussed, tend to increase and then these are the consequences of the loneliness which the GPs ultimately end up treating. There is arguably a need for earlier and more direct identification of loneliness within primary care, in order for a preventive approach to be taken and consequently avoid the resulting physical and psychological effects of unheard loneliness. This could potentially save on time, costs, and resources for the NHS in the long-term.

Greater awareness of social views and constructs

As a society we tend to hold a stigmatised view of loneliness, related to feelings of shame and embarrassment, leading to a social taboo or unacceptability about talking about loneliness. GPs felt that this was why patients did not raise the issue with them, and why they themselves sometimes found it difficult to ask about. However, GPs also stated that by having this idea brought to their attention by their participation in the study, they were prompted to consider why this held them back from talking about loneliness and declared that they would be more aware of these unconscious processes in the future. This suggests that our wider social cultural messages undoubtedly influence the way in which we think, work, and interact with others, and although this is not something that can be directly changed, there is a potential for more mindful practice to increase awareness of these influences. This could perhaps be in the shape of providing resources for discussion about the social and cultural messages that influence GPs' work and interaction with their patients.

Future research

This study focused on GPs' views and experiences of working with loneliness specifically with their older adult patients. However, GPs frequently noted in the interviews that they had noticed other groups that were presenting as lonely. For example, GPs mentioned adolescents and young people, as well as young single parents, or those who had moved to a new area and did not know many people. GPs made the point that as these groups of people tend not to be within high-risk groups as older people might be, they are more likely to get overlooked when it comes to social problems such as loneliness. Indeed, research shows a reverse bell curve in the prevalence of loneliness across age groups, depicting the highest levels of loneliness in older adults aged 65 and over, and in young people aged 25 and under (Victor & Yang, 2012). This suggests that despite the greater opportunities for socializing in terms of education and work for younger people, this is an age group that feels equally as lonely as older adults. This could perhaps be explained by the discussed view that loneliness is more than just a physical state of being around people, but an internal feeling and conceptualisation of the quality of relationships. Therefore, there is an opportunity for future research to focus on loneliness in young people, how this is viewed by them and others, as well as how the consequences of the loneliness are presented within work, education, and primary care.

The findings of this study raised some questions about our society and cultural beliefs about how problems are treated and who should hold the responsibility for them. This study was carried out in England, and GPs held a predominantly Western view of the treatment of problems, favouring a medical model and suggesting that individuals were responsible for their own health and wellbeing. This can be seen in contrast to other cultures, for example some Eastern cultures, which consider illness more

holistically, incorporating factors such as society and spirituality, and consider responsibility to be shared within a community. It would be interesting therefore to conduct research on loneliness in other cultures and societies to explore how social constructs might differ, and how this consequently affects loneliness and its management within those populations.

These implications would not only improve the experience of GPs working with social problems like loneliness, but also offer insight into the voices of the lonely patients who are presenting in primary care, and consequently improve their care and wellbeing.

Critique of Study

Strengths

There are few studies looking at GP's accounts of loneliness in their patients. The two identified studies which do this were conducted in the Netherlands and do not specifically focus on older adult patients. The present study therefore offers a unique contribution in exploring GPs' views and experiences of patient loneliness in England, thereby giving some insight into how the current system for loneliness works within the NHS. Some of the study findings mirror previous literature in the field of GPs' views of social problems, compounding the current evidence base. However, it also highlights original findings and offers new insight into this area. For example the idea that societal stigma surrounding loneliness is influencing how both patients and GPs react to it, thereby creating a vicious cycle of stigma, leading to a lack of open communication about loneliness, and consequently even further the societal idea that it is socially unacceptable to talk about. This finding not only

informs conversations in primary care, but arguably also draws on societal and cultural influences on behaviour. Furthermore, this study raises a point about the disconnect between the way in which GPs are trained and the different ways they are then being called on to work with the increasing number of social problems in primary care. This is important to note as it has an effect on patient experience as well as GPs' wellbeing at work.

This study also had methodological strengths. A suitable number of GPs were recruited in a short space of time during a busy time with competing demands on the Clinical Psychology Doctorate. Although the ethnicity of GPs was not very diverse, the other demographics showed a good spread of gender, age, years of experience, and GP location. This was aimed for in order to ensure transferability of views. This study was also approached in a manner consistent with the established epistemological views of social constructivism. For example, I used a reflective diary throughout the data collection process in order to notice aspects of the interviews which may not have come across in the verbal transcripts, but also to observe my own reactions to the answers and try to maintain a stance where I am not colluding with ideas of 'one truth' or 'one way of doing things'. As another example of this, I tried to allow GPs to lead the interviews rather than imposing my own ideas and constructions on them about how long the interviews should last or how in-depth their answers needed to be.

Limitations

As with most research, this study included a self-selected sample of participants who voluntarily agreed to take part in the study. This means that the sample is more likely

to be made up of GPs who have an interest in loneliness and older people as part of their work and practice, or those who value the input of research. This is useful in the sense that the GPs had a lot to say on the topic, however it may also mean that the study is missing the voice of the GPs who are not as interested in loneliness, or perhaps social issues as a whole. Furthermore, a number of part-time academic GPs were interviewed for this study, suggesting that they may already have had an interest in primary care research. This may arguably limit the transferability of the study findings due to some of the sample already having strong views and opinions on the topic. It is therefore important to note that these findings are not necessarily representative of all GPs working in England, nor are they claimed to be a 'truth' that exists, but rather offer a snapshot into some of the views and ideas that certain GPs held on that day and time about working with loneliness.

Although this study did intend to just focus on the views of GPs, this means that there is a lack of triangulation of views, and it just sheds a light on the views of one type of professional within primary care. If I were to do this research again, I may consider also interviewing other professionals within GP practices, such as nurses and reception staff, to gain other perspectives on loneliness within primary care. This study focused on gaining GPs' views specifically on their older adult patients, however it became clear in the interviews that GPs sometimes veered off to talk about loneliness more generally or about other age groups. Consequently, though the study aims were to gain specific ideas about older people and loneliness, the findings may include views and experiences about situations which are not exclusively to do with older adults. This made me consider the usefulness of limiting the study to a particular age group, and while focusing on older adults was not particularly

detrimental to the research, I do not believe that it necessarily added anything unique or different than would have otherwise come about if the age group had been left open. In hindsight it may have been more beneficial to not limit the discussion to older adults as the GPs would perhaps have had more to say about loneliness or had other examples to contribute.

The issue of interview length has previously been discussed in the Findings chapter, stating that although the GPs gave fairly short answers and the interview lengths were shorter than would be expected of a qualitative study, I considered this within a social constructivist viewpoint and allowed the GPs to lead the interviews rather than me dictating how they 'should' run. Despite this, upon analysing the data, I felt that the interviews had the potential for more depth and more discussion around certain ideas. Therefore the shorter length of interviews does pose some limitations in the sense that I felt more could have been gleaned from the conversations if they had been longer. As one of the challenges of recruiting GPs was their lack of time, in hindsight it would have been beneficial to emphasise the average length of interviews and time required for participation in order to give GPs advance warning to set aside a certain amount of time for the interview. In relation to the data collection, I felt as though the face-to-face interviews were of greater quality and the GPs gave more in-depth answers, as well as more time, to the interview. Therefore, the large number of telephone interviews conducted was a potential limitation to the amount of data I managed to collect. If I were to do this research again, I would ideally meet with all the GPs face-to-face, and specify this in the information pack so that GPs were aware of this.

Reflections and Learning

There is often a narrative that exists within Psychology about doctors and medics and the medical model. I have found this to be a consuming narrative about "us and them", "psychologically-minded vs non-psychologically-minded", about two types of professionals who are so fundamentally different in their thinking yet work very closely side-by-side in mental health teams. However, I am aware that I have also frequently colluded with these ideas and subscribed to the frustrated conversations and venting about psychiatrists who do not think in the same way as psychologists, and about GPs who prescribe antidepressants more than talking therapies. Throughout the process of carrying out and writing this thesis, I have changed in the way that I think about and relate to GPs (and medics more broadly). I have noticed this in the way that I talk about them with my peers in psychology training, and how the way I describe them has changed between the beginning of this study and the end of it. Through talking to numerous GPs and understanding their ways of thinking, as well as the conflicting demands put upon them, I feel much more empathy for GPs and as though I have come some way towards being able to understand what they might be feeling when dealing with loneliness, and social problems as a whole. I certainly would not feel confident or equipped enough to deal with client issues which I was not fully trained for, and I feel a lot more empathy and understanding for GPs who have to do this often on a daily basis. In my opinion this is positive learning which I will take with me in my work as a qualified psychologist within multi-disciplinary teams, as I do not believe the "us and them" conversations are particularly constructive or fruitful in moving forward, and that instead there needs to be an element of understanding of each other's perspectives from both sides.

At the start of this project I was not expecting to think about wider influences on GPs, their patients, or society as a whole. However, much of the findings have related to cultural and societal influences which we often take for-granted. For example, many of us hold Western views of medicalisation of conditions, as well as placing greater importance on individualism rather than community. As a result of this thesis, I was able to consider these wider invisible influences on us, which many of us live by because this is the narrative that pervades our language, our media, and our everyday interactions with others. It has made me more aware that nobody is immune to this, even those who are highly esteemed in society such as GPs, and that they also subscribe to the Westernised messages of our culture. Furthermore, I was aware that whilst I was describing these processes throughout the thesis, that I was simultaneously also colluding with the medicalised narrative that we hold, for example through a lot of my language in this thesis such as discourse about "managing" loneliness. It seems to me that we cannot escape the powerful influences of our culture and society, however it is important to notice that it exists and when it is affecting out work and thinking.

I have also gained some practical and research learning from conducting this thesis. Although I started this project early and gave myself plenty of time to complete it, I was nevertheless unprepared for the level of work that was required and how much time it would realistically take. Towards the final deadline I felt as though I was running out of time, and had to very quickly learn how to manage the remaining time I had whilst juggling other demands, such as clinical placements. Use of organisational and time management skills became essential at this time, and I feel that I have developed these much more throughout this process. However, I have also

grappled with the pressure that is perfectionism and wanting to produce a perfect thesis, and over time coming to terms with the fact that it may never be 'perfect' and that I could still submit a 'good enough' thesis. I have also learned to walk the tightrope of flexibility within participant recruitment. For example, recruiting GPs required a great deal of flexibility from me in terms of chasing up those who had not replied, conducting interviews over the telephone, conducting interviews in the evenings, or conducting shorter interviews during a GP's lunch-break. Whilst at the time I considered this to be a positive way of recruiting, and arguably it was to an extent, I now reflect on whether being overly flexible and lenient from the very start was conducive to collecting as much data as I could have done. For instance, I wonder if I had been more firm about how much time the GPs needed to give up for the interviews, whether I would have been able to have longer lengths of interview and perhaps gained more information. Ultimately I do not believe that this issue is 'black and white', and if I were to do this thesis again, I think that I would initially be more firm in what I wanted to gain from the interviews, but at the same time make a judgment on how flexible I needed to be in order to recruit certain GPs. Therefore my learning about recruitment is to not work robotically and hold hard and fast rules, but rather to make flexible, human research decisions for each step of the process and for each participant depending on their needs and availability.

I have gained valuable experience of conducting qualitative research with interesting participants, and this process has cemented my hopes of becoming a psychologist who also conducts research and contributes to the evidence base.

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Appendix A: Participant information sheet

General Practitioners' Views And Experiences On Addressing Loneliness In Older Adults Within Their Consultations
Participant Information Sheet

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Study summary

This study is looking at GPs' views of addressing loneliness in their consultations with older adult patients. Nearly half of people over 65 experience loneliness, which has been shown to have negative effects on their physical and mental health. This puts a great strain on healthcare services and costs, and is currently a government priority. Research has demonstrated that people experiencing loneliness tend to visit their GP more often, and place a great amount of trust in their GP. GPs therefore play a vital role in the management of loneliness in older people by spotting the early signs and offering appropriate services. Very little is known about GPs' experiences of bringing up the topic of loneliness in their consultations, what barriers there might be to doing this, and what support can be put in place for GPs to raise awareness of the

importance of identifying loneliness. This study aims to explore these areas by interviewing a range of GPs to get their views on this issue.

This research study is being carried out for a thesis as part of the Doctorate in Clinical Psychology.

Who we are recruiting

We are recruiting approximately 20 GPs who will be sampled for diversity to get a range of views. You have been selected because you were identified as appropriate by the PCRN, the researcher, or recommended by a colleague.

What will happen if you take part

The researcher will get in touch with you to arrange a time for your interview. This will be done at a <u>time and location convenient to you</u> (e.g. at your surgery after working hours).

You will only have to meet with the researcher once and this should take approximately <u>45 minutes.</u>

The researcher will explain the study to you, answer any questions you may have, and ask you to read and sign a consent form. The interview will be strictly confidential, meaning that your opinions will not be shared with anyone other than our team. The only exception to this is if you report something which suggests that either you or somebody else is at harm.

The interview will be audio-recorded during the session, using a small audio-recording device. The researcher will explain this to you and it will be indicated on the consent form.

The researcher will then ask you some questions about your views and experiences of addressing loneliness within your consultations.

After the research has been conducted, you will receive a summary of findings should you wish.

Advantages of taking part

The information you give us is very important as it will inform current understanding of how loneliness is viewed in primary care settings. By identifying barriers faced by GPs we can contribute to service improvements and ways of supporting current and future GPs in managing loneliness within older adults.

Disadvantages of taking part

The researcher will ask questions about your experiences of working with older adults experiencing loneliness, which may have the potential to evoke sensitive or upsetting feelings. If you would like to debrief with an external person after your interview, please contact **Dr Frances Blumenfeld; fblume@essex.ac.uk**. Dr Blumenfeld is the course director of the University of Essex Clinical Psychology Doctorate, as well as a qualified Clinical Psychologist.

What will happen to your data and information

Once the interview has been audio-recorded, it will be typed up and the audio-recording will be destroyed. The written copy (transcript) of the interview will be anonymised by removing any names, locations, or other identifiable information. The transcripts will be stored electronically in a password-protected file on a password-protected computer at the University of Essex. Only the researcher and thesis supervisors will have access to this data. Consent forms will be stored in paper form in a locked filing cabinet within a locked office at the University of Essex. The study will be written up for a thesis as part of the Doctorate in Clinical Psychology. It will include anonymised excerpts from the interview, with your consent. You are free to withdraw from this study at any point for any reason without your rights being affected. Personal information collected will be stored securely for five years, after which it will be destroyed.

What will happen to results of the study

The study will be written up to form the thesis for the Doctorate of Clinical Psychology, and will be available in print at the University of Essex. The findings will be presented to peers at the Department of Health and Human Sciences, and will be written up for publication in a peer-reviewed journal. Findings may also be presented at a conference.

If you are interested in the findings of this study, the researcher will send you a summary after study completion, and can present the results to primary care teams if this would be useful.

Who has reviewed the study?

This study has been reviewed for ethical approval by the University of Essex Ethics Committee, and has received favourable approval.

Who you can contact if you want to make a complaint

If you take part in this project and later have a minor complaint then please contact **Miss Ana Jovicic (ajovic@essex.ac.uk).**

If you wish to make a formal complaint or if you are not satisfied with the response to your minor complaint from the researcher then please contact the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colcester CO4 3SQ, by emailing: sarahm@essex.ac.uk or by telephoning 01206 873561.

Who you can contact if you would like to take part or would like further information

If you would like to take part in the study, or just want to discuss the process further, please contact the researcher:

Ana Jovicic

ajovic@essex.ac.uk

07875722187

Appendix B: Participant consent form

University of Essex

nep
all together, better

General Practitioners' Views And Experiences On Addressing Loneliness In Older Adults Within Their Consultations

Participant Consent Form

Please read the statements below and indicate your consent by initialling the boxes and signing below

1. *I confirm that I have read and understood the Participant Information Sheet_V2_26.05.17*

2. *I confirm that I have had the opportunity to ask questions*

3. *I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason*

4. *I consent to the use of an audio-recording device to audio-record the study interview*

5. *I agree to the use of anonymised quotes in a University research report/peer-reviewed journal publication/dissemination presentation*

6. *I agree to take part in this study*

Participant name   Participant signature   Date

……………………………..   …………………………………….
          …………………………

Researcher name   Researcher signature   Date

……………………………..   …………………………………….
          …………………………

Appendix C: University of Essex ethical approval amendment

Name: Ana Jovicic

Date: 01/12/16

Signature: _Ana Jovicic_

Description of Amendment:

The amendment is to clarify data collection methods. The protocol states that "the interviews would have to be scheduled at a time and location most convenient for the GP". This suggests face-to-face interviews; therefore this amendment is to add that some interviews may take place over the telephone if requested by the GP participants.

Reason for Amendment:

To improve participant recruitment - GPs are a particularly busy cohort and can be difficult to recruit. A potential participant has requested to be interviewed over the telephone due to time constraints.

(For office use only)

The amendment has been approved ☑

The amendment has not been approved ☐

Resubmission required ☐

Signature: _W. Willson_

Name (in block capitals): WAYNE Wilson

Department: SHHS

Date: 15/12/16

Appendix D: Original topic guide

1. How would you define loneliness?

    a. Probe on whether see it as one area, or many different definitions (e.g. medicalised, psychological, social etc.)

    b. What is your understanding of loneliness as a GP? (Would you see it differently in your personal life and your professional role?)

2. What is your experience of working with older people and loneliness?

    a. How often do you notice that a patient might be lonely?

    b. How do you know that a patient is lonely? (do they mention it directly/indirectly? Do you ever ask about it?)

    c. How do you manage the issue of loneliness when it comes up? (Probe on barriers)

3. What could be put in place for GPs to help them with identifying and managing loneliness when it arises in consultations?

    a. Is there something already in place?

    b. What are the gaps? (support, education, raising awareness?)

Appendix E: Example of analysis coding

somebody who is a bit lonely who finds relationships difficult, there are quite a lot of steps in the way that make it quite time-consuming.

[handwritten: time pressure on GP]

I: So even taking part in these things has its own boundaries and barriers. There's quite a lot to get through before that person can receive the support.

GP7: Well I think so. 'Cause the people that are going to be up for it will have done it themselves.

[handwritten: taking personal ownership/responsibility for problem]

I: Ok. And moving on a little bit to thinking about support for GPs. And this isn't a question of "should we; shouldn't we?" I don't really know so it's just your opinion.. but do you think GPs have enough adequate support for dealing with emotional things like loneliness in their patients?

GP7: [laughs] Erm, I suppose I would say that loneliness in patients is relatively low down the list on things I would need support with. And that's more because it's an identifiable issue, hopefully, for which there may be a practical solution. The frustration is in the resources and how available they are and how to access them. I'm currently involved in a project on stress and depression and anxiety in GPs, which is incredibly rife really – it's a massive issue. So I think the bottom line is GPs, for many many reasons, are not feeling supported. So I suppose that loneliness in patients is likely to be quite low down their list is they're feeling totally stressed out of their heads really.

[handwritten: frustration - unclear about how to utilise resources]
[handwritten: work stress impact on GP - wellbeing]
[handwritten: → prioritisation, self-care, self-protection]

I: Absolutely, but if they are feeling like that and then somebody comes in with, you know, feeling quite low, I wonder if that projects a little bit?

GP7: I think it's quite.. yes, and it adds to people feeling rather impotent really. I think the other thing that came out of our research, I don't know if it's relevant to yours but erm, you know the GPs that tend to get more depressed and anxious are often the ones that are more sensitive and that are more available for their patients. And so, you know, in these times when everybody's stressed and there are cuts, erm, the GPs with boundaries who probably don't pick up on the cues are protecting themselves better than the GPs who do pick up on things.

[handwritten: → GPs need to protect themselves]

Appendix F: University of Essex ethical approval

02 August 2016

MISS ANA JOVICIC
181C BELSIZE ROAD
LONDON
NW6 4AB

Dear Ana,

Re: Ethical Approval Application (Ref 15024)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

Lisa McKee
Ethics Administrator
School of Health and Human Sciences

cc.   Research Governance and Planning Manager, REO
        Supervisor

Appendix G: HRA approval

NHS
Health Research Authority

Miss Ana Jovicic
Dept of Health and Human Sciences
University of Essex, Wivenhoe Park
Colchester
CO4 3SQ

Email: hra.approval@nhs.net

26 May 2017

Dear Miss Jovicic

Letter of HRA Approval

Study title:	**General Practitioners' Views And Experiences Of Addressing Loneliness In Older Adults Within Their Consultations**
IRAS project ID:	**217137**
Sponsor	**University of Essex**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details

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and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **217137**. Please quote this on all correspondence.

Yours sincerely,

Natalie Wilson
Assessor

Email: hra.approval@nhs.net

Copy to: Ms Sarah Manning-Press, University of Essex, Sponsor contact