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research article

Questioning loneliness: an exploration of the research discourses related to stroke survival in a remote rural community in Scotland

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This paper reflects on a pilot study exploring the loneliness experiences of stroke survivors living in remote rural communities in Scotland. Empirical evidence gathered at the time of establishing this study demonstrated that there were no studies published around the subjective experiences of stroke survivors living alone in remote rural Scottish communities. Yet, stroke survivors in rural settings in other parts of the world report a longing for social contact as well as the experience of a reduction in participation in shared activities, suggestive of potential loneliness and isolation. This paper focuses on our experience interviewing one participant recruited in the early stages of the COVID-19 pandemic. Due to the pandemic, the study had to be terminated, but we were left with data gathered from this one conversation which revealed a rich narrative centred around past and present occupations. At no point was there any sense of loneliness expressed, despite the context within which this participant lived: alone, in a remote community, experiencing a degree of communication difficulties and unable to leave the house independently. All commonly hallmark 'warning signs' of a person at risk of loneliness. In this reflection we offer perspectives on assumptions and expectations of loneliness that are problematically constructed by the dominant narratives and theories at the time.

Keywords loneliness • stroke survivor • remote rural • narrative

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Introduction

Researchers, educators, legislators and providers of health and social care hold responsibility for contributing to the ways by which social issues are represented and addressed. The informing theories and conceptual paradigms of knowledge and expertise establish the foundations from which these responses are constructed.

This paper opens critical reflection on a pilot study exploring the loneliness experiences of stroke survivors living in remote rural communities in Scotland. Empirical evidence gathered at the time of establishing this study demonstrated that there were no studies published foregrounding the subjective experiences of stroke survivors living alone in Scottish remote rural communities. Yet, stroke survivors in rural settings in other parts of the world reported a longing for social contact as well as the experience of a reduction in participation in shared activities, suggestive of potential loneliness and isolation (Northcott and Hilari, 2011; Danzl et al, 2013; Yang et al, 2022). This paper focuses on our experience interviewing one research participant, recruited in the early stages of the COVID-19 pandemic.

We will use this encounter to illustrate the sensitivity and criticality needed when working with themes and issues such as loneliness. Subject areas which have high topical exposure in popular, political and academic imaginations present a challenge to researchers (Sagan, 2023) as within the dominant discourse assumptions, selectivity and omissions abound. Thus, researchers' ability to consistently apply a 'hermeneutics of suspicion' (Ricoeur, 1970) is tested, and the need to maintain free-floating attention and 'negative capability' (Keats, cited in Bion, 1970: 125) when approaching data gathering and analysis is further highlighted. We highlight in this paper the dangers of 'marching' in with a certain theoretical perspective, however grounded by our positions as researchers that may be. Such an adherence, when working with a topical subject such as loneliness, again puts us at risk of missing the bigger socio-political picture as well as the nuanced context of the person who agreed to take part in our study. Finally, we contest normative assumptions of a 'state' – in this case loneliness – to demonstrate how assumptions and discourse become baked into research funding proposals and ethical applications through language, practices, methodology and unquestioned 'facts', thereafter determining the course of the research, methods and its findings.

Stroke survival within a rural context in Scotland

Stroke is regarded as one of the leading causes of death and severe adult disability in Scotland: an estimated 11,257 people were admitted to Scottish hospitals due to stroke in 2022 (Public Health Scotland, 2023a) and despite Scottish stroke mortality rates declining in the last decade to 2022, they remain higher than in other parts of the UK (Public Health Scotland, 2023b). Stroke is estimated to account for almost 5 per cent of all National Health Service (NHS) costs, with significant additional costs to the Scottish economy associated with lost employment and loss of functional independence (NHS National Services Scotland, 2018). Stroke therefore continues to be high on the public health and quality improvement agenda for Scotland.

Stroke affects all domains of people's lives. Survivors may experience limitations arising from muscle weakness, movement disorder, cognitive and perceptual impairment, visual problems, and communication disorders such as aphasia or dysarthria (SIGN, 2010). Common complications following a stroke include fatigue (Winnall and Ivey, 2010) and psychological presentations of anxiety, depression and social isolation (Young and Forster, 2007; SIGN, 2010; Sutter et al, 2017). Loneliness has been more recently recognised as affecting the lives of stroke survivors (Petitte et al, 2015; Yang et al, 2022). Unpacking the reasons stroke survivors may experience loneliness is complex, given the interplay between psychiatric sequelae and disordered communication such as aphasia (Azios et al, 2022). It is also possible that there are subjective differences between the post-stroke recovery experiences, dependent on the context within which survivors reside, namely, rural versus urban communities.

It has been difficult to identify literature specifically examining this issue within a Scottish context. O'Neill and Godden (2003) reported on the differences of utilisation of services and functional independence six months post-stroke. They identified that survivors who live rurally spend longer in a rehabilitation setting as compared with their urban counterparts. This finding is supported by Public Health Scotland (2023b) as they report on '90-day home time' (the number of days a person spends at home within the first 90 days after stroke [Public Health Scotland, 2023b]) which tends to be higher within more rural NHS board areas, meaning that people spend longer in hospital before they are discharged home as compared with urban areas. Perhaps related to length of hospital stay, O'Neill and Godden (2003) also reported that within their cohort of participants, fewer stroke survivors classed themselves as functionally independent as compared with those living in urban settings. Twenty years later, there remains a noticeable gap in updated perspectives from a Scottish context. However, observational studies more recently conducted in the United States (Shen et al, 2022) and Canada (Allen et al, 2016) highlighted that when examining functional outcome data, there appear to be no significant differences between urban and rural dwelling stroke survivors, particularly when stroke survivors in rural areas are afforded access to home-based multidisciplinary rehabilitation (Allen et al, 2016). Such studies examine 'stereotypical' considerations of stroke survivors' recovery: '90-day home time', functional and quality of life outcome measures which are indisputably important, but they do not reveal the richness of experiences of stroke survivors living in remote rural areas. A qualitative synthesis based in Australia by Jackson et al (2021) highlighted the unique aspect of survivors' experiences in remote rural locations related to the challenge of accessing services, for example, geographical distance, lack of public transport, limited communication and inconsistent follow-up. This was highlighted alongside a sense of resilience of survivors within remote rural areas, borne out of a determination to do well in one's recovery journey, despite the challenges associated with living remotely (Jackson et al, 2021). This finding is unsurprising, given the strength people display when they are motivated to return to places of familiarity, referred to as place integration by Erikson et al (2010).

Despite the dearth of published research exploring the post-stroke experiences of survivors residing in remote and rural settings within Scotland, the policy landscape that informed this pilot study was clear: the Scottish Government was committed to improving key aspects of rural living such as the provision of public services, education and healthcare (Scottish Government, 2016). At the same time, the Scottish Government was engaged in widespread consultations on the impact of loneliness on the populous. A strategy for tackling loneliness and social isolation (Scottish Government, 2018) was published in recognition of the impact on the health of people of all ages. With these different perspectives and priorities, the pilot study was positioned to address several 'areas of interest'.

Loneliness: a pandemic?

The experience of loneliness, perhaps best thought of as one constituting an emotional cluster (Bound Alberti, 2019), is by all accounts complex (Yanguas et al, 2018). Despite this complexity, 'loneliness is empirically presented as an unproblematic concept that is universally understood and experienced homogeneously' (Victor, 2021: 51). Usually experienced as unpleasant and often distressing, loneliness narratives often describe feelings of anxiety and beliefs about a lack of connectedness or communality with others, and suggest at core a dysphoric condition, resulting at least in part, from discrepancy thinking – that is, an incongruity between one's ideal and real social relationships (Masi et al, 2011).

Termed a pandemic in the 1990s and described in *The Lancet* as a public health problem (Cacioppo and Cacioppo, 2018), loneliness headlines began to proliferate in both academic and popular imagination at least 20 years ago and it is now widely considered an international public health issue (Gerst-Emerson and Jayawardhana, 2015); a systematic review of 2022 found evidence of problematic levels of loneliness 'experienced by a substantial proportion of the population in many countries' (Surkalim et al, 2022: 1). Recognised as a priority public health policy issue for older people by the World Health Organization (WHO, 2021) there is growing public attention paid to the loneliness experienced by older adults (Victor, 2021) as well as the impact of loneliness on both mental and physical health (Leigh-Hunt et al, 2017). Loneliness is associated with an increased risk of developing coronary heart disease and increased blood pressure (Hawkley et al, 2010) as well as cardiovascular health problems (Paul et al, 2021) and stroke (Petitte et al, 2015;Valtorta et al, 2016). Loneliness has also been demonstrated to put individuals at greater risk of cognitive decline and dementia (James et al, 2011; Holwerda et al, 2012) and is shown to have adverse impacts on mental health (VanderWeele, 2011). Conditions such as depression appear to be particularly vulnerable to its impact (Erzen and Çikrikci, 2018) and neuroscientific research has identified a region of the brain believed to generate feelings of loneliness known as the dorsal raphe nucleus, or D.R.N., best known for its link to depression (Matthews et al, 2016). Loneliness and low social interaction are seen as predictive of suicide in older age (O'Connell et al, 2004) and through an interplay of factors, loneliness has emerged as increasing the likelihood of mortality by 26 per cent (Holt-Lunstad et al, 2015). Scotland was not alone, therefore, in putting loneliness on its public health agenda through creation of a national strategy on reducing loneliness and isolation (Scottish Government, 2018).

Loneliness and stroke survival

Stroke survivors living both in urban and rural settings have reported a longing for social contact (Lamont et al, 2023) as well as a reduction in participation in shared activities (Northcott and Hilari, 2011; Danzl et al, 2013). Some of the factors contributing to the social isolation of stroke survivors have been identified as social stigma associated with the consequences of stroke (Northcott and Hilari, 2011; Danzl et al, 2013), fatigue, and lack of energy and inclination for social engagement (Northcott and Hilari, 2011; Walker et al, 2013). The functional, cognitive and communication difficulties resultant from the stroke itself may mean that stroke survivors are less able to maintain social connectedness (Northcott and Hilari, 2011). The relationship between the experience of loneliness and depressive symptoms, life satisfaction and health-related quality of life have been highlighted by observational studies with a clear call for effective interventions to address this issue (Alawafi et al, 2021; Chan et al, 2021; Byrne et al, 2022 *inter alia*). Thus, loneliness was clearly on the 'life after stroke' research agenda and our study sought to contribute to this area of exploration.

The study: what was proposed and what it became

This study was first conceptualised as an undergraduate honours degree project within the discipline of occupational therapy; a review of relevant literature and a small-scale investigation proposal. The first author who supervised the original project further developed the aim and objectives of a study, originally designed as a pilot. The preliminary study allowed us to establish whether our participant recruitment, data collection and analysis methods would enable us to explore the experiences of stroke survivors living alone in remote and rural Scotland. In particular, their experiences of loneliness.

A related objective was to identify and reveal contextual factors unique to life after stroke in remote rural communities, mindful that rural and remote settings are diverse and people in these communities face unique challenges. Indeed, the term '*rural*' is understood to encompass both a socio-geographic place and a social construct (Aquilino et al, 2021), and it has been contested for revealing urban bias (Mohatt and Mohatt, 2020). We were keenly aware of the complexities of the context given that there is some evidence suggesting that rural communities experience *increased* community interconnectedness as well as higher community participation and informal support (Ziersch et al, 2009), reinforcing the need to differentiate between loneliness and social isolation in rural study (De Koning et al, 2017).

We set out to recruit four participants who had survived a stroke and who lived alone in two different remote rural locations within NHS Highlands using convenience sampling, facilitated by gatekeepers – local occupational therapists who were asked to identify potential participants to be approached by the researchers. The few criteria for inclusion were that potential participants had survived a stroke within the last 10 years and were living alone in their own home within a remote rural location in Scotland. Reasons for exclusion were for individuals affected by post-stroke dementia, or persons affected by communication disorder severe enough to preclude them from participating in an interview. Congruent with an established life story approach to narrative (Cresswell, 1998), we further planned to facilitate free-associative narrative interviews (Hollway and Jefferson, 2012). While seeking to enable free-flowing narratives, depending on how generative and forthcoming the participants were with their stories, the researchers were prepared with prompts related to important life events; experiences related to illness and health; family and social support networks; perception of community connectedness; and difficulties and challenges associated with experience of stroke.

Within health sciences, researchers have long emphasised the value of first-person narratives. This is seen as offering counter-narratives to medicalised discourse promulgated through third-person perspective methodologies that dominate the social sciences and medicine. Personal storytelling is also a means of 'sense-making' (Mattingly, 2010) about the disruption of illness to everyday life (Murray and Sools, 2014). Stories are thus important personal and cultural resources, holding a capacity to *do things* by shaping our emotions, cognitions, beliefs and experiences through the witnessing and telling of stories. That said, the 'use' of voice in health research is hotly and rightly contested (Pascal and Sagan, 2018) with many researchers becoming increasingly unsettled by user narratives being co-opted by mainstream institutions and policy (O'Donnell et al, 2019) with some now pursuing the recovery of such stories (Costa et al, 2012). With such provocations in mind, this study endeavoured to maintain what Finlay (2014) termed phenomenological sensibility, staying close to the lived experience as given through the first-person narrative of the stroke survivors.

The study received approval from NHS Highlands and the North of Scotland research ethics committee in March 2019 and it was sponsored by Queen Margaret University. We received funding support for the project in no small part because of its focus on governmental areas of concern: stroke survival, rural living and loneliness. This is hardly new; researchers have long been acutely aware of the need to link their research endeavours to areas of inter/national policy interest. Nevertheless, we note here that from the outset, at the point of writing the proposal, we already drew on discourses of loneliness and extant literature in the field to make our case, flagging up the first warning sign of how easy it is to thereafter frame methodology and subsequent 'new' findings within a framework of 'old' assumptions thereby reproducing an increasingly critiqued reductionist, policy-driven approach to loneliness in academia (Christou and Bloor, 2021).

The recruitment process of potential participants who met the inclusion criteria reflected known challenges of participant identification using gatekeepers (Spacey et al, 2021). Several months passed before the researchers were notified of an individual who met the inclusion criteria and who was interested in the study. Initial contact was made following on from which the multi-staged consenting through the gatekeeper was completed. The participant's occupational therapist, and research gatekeeper, was confirmed to be present for the interview to support the process.

From the inception, the data generation was envisioned to be carried out in a participant's own home, unless an alternative was requested. The empirical rationale for this interview context emerged both from the geographic variables of the study as well as the occupational therapy understanding of the dynamic interaction between a person, their environments and the daily activities (occupations) that generate meaning in their lives (Mohotlhoane and Nemakanga, 2023). We knew that 'context matters' in the ways that stories are offered and shared; we had not envisioned how central the home environment could be in serving as a defining character in the narratives within this study. The interview was arranged for early March 2020, just weeks before the UK government mandated national COVID-19 restrictions. Given the changing circumstances in relation to the pandemic as well as the fact that the study was no longer classed as a research priority (that is, not COVID-related research), we consulted with the local ethics board and were offered the option of continuing with the study using video conferencing technology. We knew that where the interview took place was far more significant than merely '*the setting*' for the data collection, and therefore took the decision to terminate the study in June 2020. However, the COVID-19 disruptions to research ironically and somewhat fortuitously allowed us an unanticipated opportunity to reflexively appraise our methodological approach. It was this liminal breathing space that ultimately allowed for some insights to emerge both about our study and loneliness study more generally. The following sections outline the encounter with the participant (hereafter referred to as James) and the moments of realisation of the researchers during the encounter that the dominant narrative of loneliness that originally underpinned this study was flawed.

The encounter: James

The gatekeepers facilitating the recruitment for our study were living and working within the same area, holding first-hand knowledge of stroke survivors' specific rehabilitation requirements and their contextual realities. The gatekeepers are individuals whose work does not provide immunity to the influence of dominant discourses or subjective interpretation of loneliness, although to suggest they may have been influenced in their gatekeeping by this is an overreach. On paper, James met the recruitment criteria: he was a stroke survivor who had been discharged to his home environment in a remote village in rural Scotland and he was receiving ongoing community-based physical rehabilitation to support and facilitate independent mobilisation outside the immediate home environment. James was also living with expressive aphasia, a communication disorder which, until recently, may have excluded him from narrative-based research (Kristo and Mowll, 2022). James therefore 'ticked many of the boxes' indicative of being at risk of loneliness.

Sense-making and situatedness

Two of the research team (both trained occupational therapists) undertook the journey to travel to James' remote location to meet him. In becoming immersed in James' geographies and his life-world contexts, immediate concerns and assumptions could have been raised about a potential loneliness experience emerging from his narrative: he lived alone, he was reliant on others to engage with the community outside his house, he had expressive aphasia. Yet in listening to his narrative, loneliness was not mentioned or inferred once. James' narrative traversed the different landscapes on which he had and currently resides, revealing a situatedness and intersubjective connection with space and place (Jackson, 1996) that is not readily presented in loneliness research (Holton et al, 2023). To meet and speak with James was also to meet and speak with the lands upon which his life narrative and sense of self evolved in relation to his local community. The relevance and resonance of such 'moments of meeting' (Stern, 2004; Elliot and Bonsall, 2018) were not anticipated in the research design yet dominated the reflective discussions following the interview.

The researchers and James' occupational therapist entered his central living space that through post-stroke necessity had been converted into a lounge and a bedroom. A large window dominated one wall and seemed to extend the indoor space into the natural features of the village. Casting our eyes around the room, we were struck by the evidence, beauty and importance of James' hobbies in capturing the moods and changes of the outdoor landscape. One of the researchers, taking a seat near the window, made a personal comment that situated themselves amidst such environments; across the room, amidst James' artistic renderings, the other researcher's occupation-focused question resulted in a differently situated connection with this man living in a remote village. By entering the field of view that he witnesses on account of his mobility, both researchers together and separately found themselves within the narrative James began to share, and the vitality of its meaning apprehended through 'experience-near' research (Hollway, 2009). With the first author establishing a shared leisure pursuit history, and the second author's familiarity with James' current occupational interests, the interview commenced from a single question. "Please tell us what it is like for you, living here. Maybe a little bit before the stroke and how it is for you now." Over 60 minutes James constructed the narrative he wished to share, not necessarily the narrative he might have felt we came to hear. Working through what appeared to be frustration at and fatigue from his aphasia, James shared insights and memories from his previous and current realities as a person who experienced living in various rural and urban Scottish communities. We listened attentively and curiously, inviting clarification when the story or the storytelling was unclear.

Though not originally from the village he now considers home, James had held many jobs and roles 'giving to' the community, yet now, he was a recipient, the beneficiary of support from within his community. His physical world is limited to the space through which he can ambulate, yet his social and reflective world extends through the vistas afforded by a large central window. The study aim was not to explore the subjective wellbeing, though there is resonance with the narratives shared by James that his relationship with his space may be a contributing variable (Douma et al, 2021). While motioning with his unaffected arm to the stories told through his many creative projects, James also shared stories imbued with darkness and difficulty that preceded the stroke. James seemed to grieve the loss of his former identities, capabilities and connections and this was our sense of his story 'in the moment'. When the interview was concluded, we recorded our reflections while driving away. We clearly recognised at the time, that in no moment during the hour-long interview, did James discuss or hint at loneliness. We did not know at the time that James would be our only participant within this study; but we knew we had to consider his story with a fresh outlook as even in those early moment after the interview, before the recording was listened to, we knew that we would not be able to misconstrue his story as a precursor to or risk factor for loneliness. We were, as Welty (1983) differentiated, required to listen to his story, and not for our story. Had we attempted to represent James in such a way, it would have been through our own narrative lens, drafting the story we were hoping to find.

The COVID-19 pandemic necessitated that we shift our attention from the project itself to 'fire-fighting' as academics who had to utilise new ways of delivering learning, teaching and assessment. This inevitably resulted in a hiatus, where we had to let the data collected 'rest'. Once we recovered our way of being in the new world, we had several reflexive conversations as a team, where we were able to critically appraise the data we had, leading to our understanding that we had to actively examine the sources of knowledge that might have led us to problematically categorise James' experiences (Hollway and Jefferson, 2013). Our reflexive team discussions over the weeks that followed allowed us to recognise the importance of this narrative in potentially disrupting the normative discourse, as well as the assumptions and expectations of loneliness. Greenhalgh's (2021) work offers our analysis additional perspectives of moral uncertainty. We take courage from Greenhalgh's (2021) sensitive awareness of the tension between moralising and complicating morality. In our study, the question was not 'what to do' but rather 'how to understand'; the consideration of James from different angles and with a different gaze and therefore a different sense-making experience.

Seek and find

As highlighted in the introduction, this study was conceived at a time of increased social, medical and political interest in discourse related to loneliness. Other researchers exploring living with stroke in rural environments were influenced by this intersectional consideration of people living-in and living-with certain contexts as being 'at risk' (Yang et al, 2022). Yang et al (2022) conducted a comparable study in England, establishing loneliness from the outset. It was identified clearly in their articulated research aim (p 2540): 'to explore and discover the meaning of loneliness specific to stroke survivors in Northeast England', an area of increased social deprivation and therefore at risk of stroke according to the research cited. In the publicly available (online) recruitment materials, their participant information sheet presented the researchers' sample population like our own, thus, no experience of loneliness was required. Yet in their publication, data from one recruited participant were excluded from analysis because 'the respondent did not comment on loneliness during their interview' (Yang et al, 2022: 2541).

With a critical gaze to the research methodologies and methods typically employed in qualitative research, a theoretical and reflexive imperative is necessary. Is this a study exploring experiences of stroke survivors in remote and rural locations that *may* include experiences of loneliness? Has loneliness already been established, and the research aim is an examination of how loneliness impacts, exists and implores meaning in the daily experiences of stroke survivors? We cannot comment on the research intentions of others, but we do offer the epistemological caution that research design and dissemination constructed within dominant narratives of loneliness risk reification of all individuals within a particular category. In other words, the individual experiences and narratives of stroke survivors may become reduced to a single narrative aligning stroke, geography and loneliness. This is particularly concerning if the exceptional narratives, such as the individual who did not voice or claim the language of loneliness, are excluded from the analysis.

Disruptions of loneliness discourse

Recognition of the limitations of loneliness research with its somewhat reductionist metrics is growing. Karnick (2005: 11) finds the experience 'not adequately addressed' in the existent literature in healthcare fields, pointing to the tendency to regard loneliness as a 'social deficit problem' with the reproduction of unwarranted stereotypes. Victor (2021) noted that despite its complexity, empirically, loneliness is presented as a concept that is universally understood and experienced homogeneously, with concerns that definitions and measures of loneliness may inhibit the revelation of the cultural context and heterogeneity (van Staden and Coetzee, 2010). Calls are thus growing for research 'to account for diverse intraindividual experiences and trajectories of loneliness' (Akhter-Khan and Rhoda, 2020: 1).

Loneliness, first constructed post-industrialisation (Bound Alberti, 2019), has intensified during the march of capitalism into neoliberalism, with the latter's promotion of competition, for example, widely claimed to be undermining a sense of solidarity and social security (Piketty, 2015). Becker et al (2021) argue that neoliberalism 'appears be harmful to health because it can create a sense of being disconnected from others, as well as being in competition with them, in ways that feed feelings of loneliness and social isolation' (p 962). Yet we continue to find studies which either locate loneliness in the individual or present a narrative relatively bereft of socio-political context.

This paper raises pressing questions about the relative lack of bidirectionality and intersectionality in loneliness study in health and the relatively scant attention paid to context, situatedness and to methodological assumption. While the evidence of a *correlation* between ill-health and loneliness is irrefutable, headline panic, deficit language and the overwhelming individualising tendencies of loneliness study are deemed erroneous if not harmful, arguably performing medicalisation through popularisation. In speaking to James within the parameters of a study that 'expected' to find loneliness, and which bore the hallmarks of a population vulnerable to its experience, we found something very different.

Conclusion

Disruption, accident and the drive to maintain a critical and open stance to what was unfolding in our research led to a very different outcome to that which may have been anticipated from our original proposal and study design. We expected to find a narrative of loneliness (Sagan and Miller, 2017) but instead we found a narrative of agency and purpose and a life led meaningfully, but it was only by accident that this alternative narrative could emerge: the accident of COVID-19 'disrupting' the trajectory of our study into loneliness; the accident of 'loss of participants' meant we had time and inclination to re-set our approach and linger in one encounter; the accident of finding that in 'salvaging' one person's narrative from the debris of a 'failed study' we were led to ruminations, explorations and critical examination of the expectations of a loneliness study that perhaps we would not have been afforded had the study run its planned course.

Part of the provocation of this paper is to loneliness researchers to question and re-question the discourse of the so-called 'silent pandemic' (Wood, 2013) and to attend to spatial and societal-level influences on loneliness. We also echo the urging of Power et al (2018: 229) that loneliness research be grounded 'in what individuals experience as loneliness, rather than on prototypical or stereotypical understandings of the concept'. We hope that our experience will enthuse others to critically expose the potential harm the discourse is doing in failing to properly contextualise the experience of loneliness. We urge that we delve into the myriad of ways in which the human being is managing its threatening contours and that we help restore a sense of agency into the participants with whom we engage and desist from undermining the very real, tragic and haunting sense of loneliness that many people *do* experience every day, poignancy of which is lost in the chatter about pandemics, epidemics and public health warnings.

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Conflict of interest

The authors declare there is no conflict of interest.

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