To support and not to cure: General Practitioner management of loneliness

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ABSTRACT

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 feel 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. The aim of this study was to explore GPs' views and experiences of loneliness within their older adult patients, to understand whether GPs were aware of the extent of loneliness within their patients and their level of feelings of agency. Nineteen UK GPs were recruited using purposive sampling and snowballing techniques. Individual semi-structured interviews were conducted either in person or over the telephone. Data were analysed using thematic analysis. Four over-arching themes were identified from the data: 'Whose responsibility is it anyway?', Pandora's box of shame; keeping distance; and community responsibility. Themes emphasise that GPs tend to hold a medicalised and individualistic view of loneliness. This intensifies stigma which in turn creates barriers to raising the topic. GPs felt powerless in their ability to fix the 'problem' and tended to believe that the solution had to lie in the community, the individual or in social care rather than in primary care. The findings are discussed in the context of literature on GP management of other social problems which give rise to similar issues concerning the restrictions of the medical model and the need for joined up approaches in which the GP is one part of a wider social support structure. It is suggested that it might be useful for training and support for GPs to address management of social problems jointly rather than training specific to loneliness which GPs tend to see as peripheral to their core remit.

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Key words: Loneliness; older adults; general practitioners; primary care; qualitative; thematic analysis

What is known about this topic:

- Nearly half of all older adults in the UK report feeling lonely; people experiencing loneliness tend to visit their GP more often
- There has been a rise in patients presenting to primary care with social problems
- GPs tend to feel frustration and powerlessness when working with difficult social problems

What this paper adds:

- GPs tend to view loneliness as an problem in the individual but for which the cure must come from the community
- There is a stigma surrounding the experience of loneliness, which prevents GPs and patients talking openly about it
- There is a need for more joined-up working between GPs and social care to avoid medicalisation of social problems, as well as more training and support for GPs in working with social issues

INTRODUCTION

Peplau & Perlman (1982) define loneliness as a person's social network being deficient for their needs rather than simply a material absence of company. Drawing on Bowlby's (1969) theory of attachment, they note 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. It is understood that social bonds are naturally sought out in order to gain and maintain a sense of belongingness, which has numerous positive effects on physical and mental wellbeing (Baumeister & Leary, 1995). However, it is possible to be alone and not lonely, as well as lonely when not alone (Wenger, Davies, Shatahmasebi, & Scott, 1996) which suggests that loneliness is something to do with the *quality* of people's relationships and the individual's perception of their interactions with others (De Jong Gierveld, 1998).

It is estimated that over 9 million adults in the UK experience loneliness either always or often (Campaign to End Loneliness, 2019), matching a similar prevalence rate in the US (KFF, 2018), and it is estimated that loneliness can be as detrimental to health as smoking 15 cigarettes per day (Holt-Lunstad, Smith, & Layton, 2010). This concept of loneliness as a 'disease' or a threat to health (Tiwari, 2013) is controversial. Loneliness is not currently a psychiatric diagnosis nor is it routinely screened in primary care (Meyer & Schuyler, 2011), but it has been argued that it should be addressed as though it were a public health problem (Pies, 2010). There may be some arguments for doing so given that loneliness, particularly in older people, has been linked to functional decline and death (Perissinotto, Cenzer, & Covinsky, 2012), higher mortality (Luo & Waite, 2014); admittance to hospitals or nursing homes (Mor-Barak & Miller, 1991), higher blood pressure (Hawkley, Masi, Berry, &

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Cacioppo, 2006), association with heart disease (Thurston & Kubzansky, 2009), poor sleep, a worse immune system response and depression (Luanaigh & Lawlor, 2008), decreased self-esteem, increased anxiety and anger (Cacioppo, Hawkley, Ernst, Burleson, Berntson, Nouriani, & Spiegel, 2006), greater risk of suicide in later life (O'Connell, Chin, Cunningham, & Lawlor, 2004), greater risk of developing dementia (Holwerda, Deeg, Beekman, Tilburg, Stek, Jonker, & Schoevers, 2014), decreased physical activity (Newall, Chipperfield, Bailis, & Stewart, 2013), higher medication use (Cohen, Perlstein, Chapline, Kelly, Firth, & Simmens, 2006), and greater risk of alcohol misuse (Immonen, Valvanne, & Pitkala, 2011).

Loneliness is not restricted to older adults and is most prevalent in younger generations and older generations, specifically those aged under 25 and those aged over 65 (Victor & Yang, 2012). It is nevertheless often associated more with ageing as a result of adjusting to retirement, the death of friends and spouses, deteriorating physical health, and financial issues which may limit travel (Which Elderly Care, 2016). 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). Whilst for older adults' loneliness may arise from circumstances that come with later life, in young people it may be more connected to changes in life and identity roles, as well as personality traits (de Jong Gierveld, 1998; Victor, Scambler, Bowling, & Bond, 2005).

Primary care physicians are traditionally trained to manage physical health problems and treat them using medication or referral to specialist services. However, in the UK, primary care is seeing an ever-increasing rise in 'social problems' such as homelessness and issues like loneliness (The King's Fund, 2016). This trend may reflect a greater awareness and

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acceptance of non-physical health concerns and/or a decrease in stigma, leading to greater numbers of patients seeking help for these problems within primary care, or it may reflect a decrease in community and social support structures such that General Practitioners (GPs) have become the only accessible form of formal community support. The medical model taught in medical schools is predominantly a Western framework based on a diagnose and treat concept (Shah & Mountain, 2007). Yet GPs frequently encounter problems of a more social nature which do not fit this model well (McPherson & Armstrong, 2009). This disjunct might be a factor in the medicalisation of social problems, that is, placing a label on a social problem and treating it using medical constructs (Maturo, 2012; Rapley, Moncreiff, & Dillon, 2011).

Working with social problems can influence GPs' workload, and also their feelings about their patient and themselves. Working with psychological issues can be more time-demanding for GPs and require more time spent diagnosing the problem (Zantinge, Verhaak, Kerssens, & Bensing, 2005). McPherson, Byng and Oxley (2014) noted that GPs avoid asking follow-up questions about social issues as this could lead to conversations that do not follow the medical conversation format and might lengthen the conversation. People experiencing loneliness have also been found to have higher frequency of consultations with a GP (Ellaway, Wood, & MacIntyre, 1999). This is possibly due to the fact that it can take patients longer to raise the issue of loneliness owing to perceived stigma (de Jong Gierveld, 1998), but at the same time wanting a form of social contact through the GP. 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 people experiencing loneliness to access a

level of social contact by presenting with a physical complaint instead, whether they are consciously aware of this or not.

Recent literature has focused on the rise of 'social issues' (e.g. loneliness, housing, finances) within general practice and medicine in general, and debate has emerged around whether this is a role for medics at all (Krishnamoorthi, 2010; Kaplan, 2016). Due to the recent changes within the GP role in terms of service funding and allocation, the present study acknowledges that GPs will hold some power around management of social, as well as medical, problems. The study will therefore explore GPs' experiences of the level of loneliness encountered within their practice; consider the interplay between the medical model framework and the social presentation of loneliness; explore the perspective from which GPs view the management of loneliness and the sense of agency they feel they have in its management; and considers the future role of GPs in addressing loneliness as a social issue.

METHODS

Design

A qualitative study using semi-structured interviews was carried out. 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).

Participants

Participants were GPs working in England, UK, purposively sampled for diversity in age, gender, years of experience, ethnicity, and working in urban or rural settings. Based on

experience of numbers for saturation in similar studies, and recommendations for medium-sized studies using thematic analysis (Braun & Clarke, 2013), the aim was to recruit a maximum of 20 GPs.

GPs were eligible to take part in the study if they were fully qualified, currently employed as a GP, working in England, and were English-speaking. GPs were not eligible to take part in the study if they were medical students or GPs-in-training, retired or ex-GPs, or non-English-speaking.

Recruitment

Ethical approval was obtained from the University of Essex. As this study only involved 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.

GPs were recruited using a snowball sampling technique in which the researchers approached primary care physicians known to them and asked them to pass information about the study to their own contacts and colleagues. Any GPs who then came forward to participate were also asked to pass the information on to their contacts and colleagues. Once the initial phase of recruitment using this sampling method had taken place, the demographics of recruited GPs were reviewed and gaps were identified. Purposive sampling was consequently used to identify and recruit GPs from under-represented groups. This was done through online searches of GPs on public information websites. GPs identified in this way were sent study information directly and asked to contact the researcher if they were willing to take part. Participant information sheets explained the voluntary nature of participation and that they

could withdraw from the study at any point. Participants were also made aware that interviews would be confidential, except where the participant or somebody else was deemed to be at risk of harm. Written consent was gained from all participants with the use of signed consent forms. Participants were not offered any financial compensation for participation.

Data collection

Data collection took place between November 2016 and December 2017. Participants took part in a semi-structured interview exploring key topics whilst permitting further probing of other issues which may arise during the interview. The topic guide was purposefully broad to allow exploration of different views and experiences relating to loneliness that the GPs brought to the interview. The key topic questions were:

1. How would you define loneliness?
2. What is your experience of working with older people and loneliness?
3. What could be put in place for GPs to help them with identifying and managing loneliness when it arises in consultations?

Interviews were audio-recorded and later transcribed and for the purposes of analysis. All transcripts were anonymised.

Analysis

Thematic Analysis (TA) was used to analyse the data. TA is a flexible form of qualitative analysis, which accommodates a range of epistemological positions and can be employed inductively or deductively (Braun & Clarke, 2006). It is comprised of 6 steps: Familiarisation with the data; Generating initial codes; Searching for themes; Reviewing themes; Defining

and naming themes; Producing the report (Braun and Clarke, 2006). We employed an inductive 'bottom-up' approach in order to generate meaning from the data without imposing any specific hypotheses in advance. 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. The manuscripts were coded by one researcher due to the epistemological stance of the original thesis study, however themes and sub-themes were reviewed by both researchers.

FINDINGS

Nineteen GPs (11 females and 8 males) took part in the study. Their ages ranged from 31 to 62. Their years of experience ranged from 1-32 years. They were based in a mixture of urban (13) and rural (6) practices. Most (15) were White British, with one GP identifying as Indian, one as White Irish, and two as Other Asian Background. About half of the interviews (8) were conducted face-to-face and the other 11 were conducted by telephone. Interviews ranged from 13-40 minutes, with an average length of 25 minutes.

Four over-arching themes were identified from the data: Whose responsibility is it anyway?; Pandora's box of shame; keeping distance; and community responsibility. Quotes used indicate the GP's gender, whether their practice is urban or rural and how many years experience they have as a GP.

Whose Responsibility Is It Anyway?

Although GPs talked about loneliness as a social problem, they largely framed their discussion of the issues within a standard Western medical framework characterised by notions of 'diagnose and treat', individual responsibility and individual risk factors as though

loneliness were a disease or syndrome. Within this framework, it was clear that GPs found themselves in the position of identifying the problem once it showed symptoms, rather than preventing it in a public health sense, which could be felt as too late in the development of the 'disease':

> *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* (female, rural, 10 years)

Further reflecting on this medical framework, GPs used highly medicalised language while also acknowledging that their training predisposed them to this approach:

> *There isn't the same kind of "you've got symptom A, B, and C, so therefore prescribe D, it doesn't work quite like that* (male, urban, 35 years)

> *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 [loneliness] isn't important, all I'm saying is it tends to, it's sort of secondary isn't it?* (male, urban, 29 years)

Reflecting the concept of individual responsibility for health typical in Western medicine, GPs emphasised the importance of patients needing to take responsibility to help themselves:

> *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?* (female, urban, 1 year)

The corollary of this is that the patient's situation was deemed a result of their own behaviour or of harbouring risk factors that predispose them to catching the 'loneliness disease':

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 (male, urban, 26 years)

There was some acknowledgement that the GP was in a position to be able to offer some support to people struggling with this 'illness', yet this was also sometimes couched in terms of patients needing to earn that support through behaving as a good patient and not 'abusing' the medical support on offer:

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 (female, urban, 32 years)

This 'abuse' may allude to 'over-use' of the GP's time or of GP appointments for emotional support, rather than a medical need. Arising from this medical framework which shaped GP discussions of loneliness, came conflicting ideas around whether loneliness should be managed within or outside of general practice and whether it was a medical or social problem:

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

(female, rural, 31 years)

These conflicts, sometimes within the same GP may reflect a wider incongruency between the medical framework and discourse within which GPs are trained and the GP's role as the

first or only point of professional contact for people living in the community experiencing social difficulties.

Pandora's Box of shame

GPs were reluctant to open up conversations about loneliness with their patients. Ostensibly this was a by-product of the general practice appointment system which is based on an assumption that all types of medical problem are equivalent in terms of the time needed to diagnose and prescribe. GPs implied that the consultation time limit (in the UK this is now 7 minutes per patient) was too short to explore social issues in depth. GPs commented that they would normally be running late on a daily basis with appointments adding to the pressure to conduct speedy diagnoses and treatments. Opening up a conversation about loneliness does not fit this framework as it has an unpredictable conversational trajectory which is hard to manage and close down quickly:

> *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 you start prying and it all comes out, then it's essential you deal with it and you deal with it properly* (male, urban, 26 years)

The convention of short functional exchanges in the primary care setting was implicitly acknowledged in the way that GPs suggested they would suspect loneliness in cases where patient contravened this unspoken rule:

> *Some patients will just come in quite a lot for minor things or for no apparent reason than have a chat…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?* (female, rural, 3 years)

Yet recognising this possibility would not naturally lead to the GP opening up a conversation about it. While time, as well as not knowing how to help, were ostensible reasons for this, a more fundamental reason appeared to be an implicit idea that there is a social stigma about being lonely, and that is something patients will be ashamed of and therefore asking about it will upset them: "I think probably the biggest is the fear of causing upset" (female, urban, 7 years). Some GPs felt that asking patients directly whether they were lonely was "cruel" (female, urban, 32 years) and "not terribly effective" (male, rural, 24 years). Whether or not patients do experience shame around loneliness, it would seem that GPs have the potential to exacerbate any shame by behaving towards patients as though it is an issue that is too embarrassing for the patient to ask about, even though GPs regularly ask patients about other potentially embarrassing issues concerning their bodies. Where GPs did attempt to talk to patients about loneliness, they seemed to prefer indirect questions:

> *You would tend to ask about support networks and contacts and how people spend their time and those kind of questions.* (female, urban, 7 years)

In considering whether to ask patients directly about loneliness, this was only considered as an option in terms of the possibility of the patient acknowledging the issue and taking responsibility:

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. (female, urban, 27 years)

Keeping Distance

GPs spoke about their own emotions when working with lonely patients. These included guilt, hopelessness, sadness and frustration. There was a clear sense of empathy for patients who were 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* (male, urban, 26 years)

Yet there was also a sense that empathy was no substitute for having the same power to treat as doctors may be used to feeling when faced with straightforward medical problems:

> *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* (female, rural, 10 years).

This frustration could be compounded if patients were not behaving as 'good', responsible patients, preventing doctors from being able to provide a fix:

> *Some people will look at that booklet* [of social prescribing] *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* (female, rural, 10 years)

In discussing loneliness, participants turned to reflecting on GP stress and burnout, suggesting that loneliness may be an aspect of general practice which generates a form of emotional contagion contributing to poor wellbeing among GPs:

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... people I think retiring earlier, maybe that's a reflection (male, urban, 26 years)

GPs described ways of protecting themselves from this emotional contagion which appears to convey an idea that patient emotions are a threat to GPs and that a GP's job is to inoculate themselves against these threats by keeping emotional distance:

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 (female, urban, 27 years)

Community Responsibility

Although GPs used medical discourses and medical frameworks in talking about their encountering of loneliness in practice, when considering solutions there was a sense that these were not generally to be found within the medical framework. It was suggested that medical schools are not interested in covering loneliness within the curriculum and that while training on consultation style, for example, might be useful, this would not be widely welcomed:

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 (male, urban, 24 years)

The solutions commented on were largely to be found outside of general practice and in social care or the community. A common suggestion hinged around the notion of key individuals based in the community such as care navigators, community support workers, or social workers to whom the GP could send lonely patients and who could then have the time and resources to help the patient with more 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* (female, urban, 7 years)

There was a wish for more funded services which should be in the community, suggesting that the way to deal with loneliness was outside of medicine:

> *.. 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* (female, rural, 3 years)

It was also seen to be the responsibility of the public and communities to be aware of lonely people, especially older people implying that public individualism was seen to be one of the causes of loneliness:

> *...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* (female, rural, 3 years)

DISCUSSION

There are very few studies looking at GPs' accounts of loneliness in their patients. The issue has been examined in the Netherlands (van Ravesteijn, Lucassen, & van den Akker, 2008;

van der Zwet, Koelewijn-van Loon, & van den Akker, 2009), where there were similar findings in terms of addressing the issue indirectly, time constraints, a sense of frustration and powerlessness along with empathy. There is also limited research exploring GP's ideas about social issues in the primary care setting more generally. These have been explored in relation to partner violence (McCall-Hosenfeld, Carol, Perry, Hillemeier, & Chuang, 2014), homelessness (Jego, Grassineau, Balique, Loundou, Sambuc, Daguzan, Gentile, & Gentile, 2016), and sickness certification (Swartling, Alexanderson, & Wahlstrom, 2008). These studies have found similar difficulties with discussing social issues with patients, with the lack of time for the conversation being a common issue (McCall-Hosenfeld et al., 2014; Swartling et al., 2008; Taft, Broome, Legge, 2004; van Ravesteijn et al., 2008; van der Zwet et al., 2009). Similarly GPs commonly comment on the lack of referral options or access to resources preventing them asking questions about social problems (McCall-Hosenfeld et al., 2014; Swartling et al., 2008; Taft et al., 2004; van Ravesteijn et al., 2008; van der Zwet et al., 2009).

While these more technocratic barriers were brought up by GPs in the present study in a similar way, the more fundamental problem of shame and stigma emerged slightly differently. Van der Zwet et al (2009) noted that patients felt ashamed to bring up loneliness with their GP and that GPs cited stigma 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). In the present study, findings emphasise that the potential for shame and stigma to be associated with loneliness can be exacerbated by GPs' unwillingness to talk about it because they assume the patient may be offended or upset. In this sense we might consider the extent to which the medical framework within primary care, which is based on an idea of a flawed

individual, restricts GPs' willingness to talk about and manage loneliness as a social problem and thereby does further harm by promulgating the sense of stigma associated with it.

Some studies have 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 et al., 2016). There is therefore potential for GP care to include discussions of loneliness; however in order for this to feel manageable it would require the availability of community resources and systems that patients could be referred to.

Similarly, Jego et al (2016) found that GPs believe they 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). In their study about homelessness, they suggested that GP practice should 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). Considering the findings of the present study, the GP's role within loneliness may be best seen as a conduit to community systems, whilst remaining a continuous link with the patient's social support structure.

Despite the GP role often being seen as medical and pragmatic, the present study, as in previous studies of GPs working with social problems, finds GPs sharing a side of themselves not often seen by patients. In the present study GPs demonstrated both empathy for their patients as well as elements of pity, annoyance, and frustration. Similarly, GPs demonstrated both pity and annoyance in other studies (van der Zwet et al., 2009) as well as sadness and frustration when patients do not comply or help themselves (Taft et al., 2004). As in the present study, GPs have also expressed feelings of powerlessness and demoralisation at not

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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).

GPs appear to protect themselves from these arising feelings by keeping their emotions separate from their clinical work and creating barriers between themselves and the potential emotions that may be evoked from working with social problems (van der Zwet et al., 2009). They may avoid discussing the problem with patients 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). This also needs to be considered within the range of current limitations that GPs face, such as reductions in funding and the short amount of time each appointment is afforded, which may prevent them from wishing to open up a "Pandora's Box". This suggests that there are some common issues that arise for GPs in dealing with a range of social problems, including loneliness. Furthermore, while GPs may not value specific training or new policies on managing loneliness, it could be useful to provide such training in a broader context that addresses a wide range of social problems and how these might be managed within GP practice in a similar way.

On the whole, the present study suggests that an inculcation into the medical model means that GPs tend to frame all patient symptoms (including social ones) as individual flaws which GPs treat in the individual while keeping themselves safe from contagion. At the same time GPs hold a contradictory stance that the real solution as well as the real cause of loneliness lies in the community and society. These mutually contradictory frameworks create a barrier to developing ways of working with patients' social problems and a recognition and discussion of this could facilitate a shift in thinking and practice towards more joined-up working between social and medical services.

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Strengths, limitations and future research

Although this study focused solely on the views of GPs, most of them White British, meaning that there is some lack of diversity and triangulation of views, it nevertheless provides some new insight into the issue. In particular, the study found that societal stigma surrounding loneliness may influence how both patients and GPs communicate with each other, creating a vicious cycle of stigma, and a lack of open communication about loneliness. Further research could explore how social constructs might differ within different cultural contexts including those with more collectivist values, and how this consequently affects loneliness and its management within those populations. This could help to inform development of approaches in primary and community care that aim to address loneliness and other social problems faced by people living in communities. It may also be beneficial to explore the views of service users themselves in the reception and management of their loneliness within general practice.

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