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Social contacts and loneliness in people with psychotic and mood disorders

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Abstract

Background: Social relations can be measured through: a) objective indicators, i.e. the number of social contacts in a given time interval or b) subjective indicators, i.e. feelings of loneliness. Comparing subjective and objective indicators in patients with psychotic and mood disorders may help to understand whether diagnosis-specific interventions should be designed for increasing their social relations. In this study we assessed social contacts outside home, work environments and mental health services, which may be increased by these interventions. We also explored feelings of loneliness which could influence readiness of patients to participate in interventions.

Methods: 100 patients in outpatient mental health care were asked to: a) list their social contacts; b) report their feelings of loneliness on a validated five point Likert scale. Multiple logistic regression models were used to test associations of diagnostic categories with: a) having more than one social contact in the previous week; b) reporting at least moderate feelings of loneliness.

Results: Patients had on average 1.7 (SD = 1.7) social contacts in the previous week (median = 1.0); 77 patients reported at least moderate feelings of loneliness. Patients with psychotic disorders (n = 30) showed a statistical trend towards having just one or no contacts in the week before the assessment (Odds ratio, OR = 2.246, p = .087). Patients with mood disorders were more likely to report at least moderate feelings of loneliness (OR = 2.798; $p < .05$).

Conclusions: Patients with psychotic disorders, compared to those with mood disorders, may be less likely to report feeling lonely although they tend to have less social contacts. Strategies to enhance social relations of people with psychotic disorders may include approaches to increase patients' drive to establish new social contacts and to emotionally support them in this process.

1. Introduction

Social isolation can be defined as "living without companionship, social support, or social connectedness" [1]. It has been identified as a strong predictor of long-term morbidity and mortality in the general population, comparable to established risk factors such as hypertension, diabetes, smoking and excessive alcohol consumption [2–3].

For people with severe mental disorders, social isolation may have further negative consequences. Having social relations can help these people cope with stressful factors which are potentially harmful for their mental health [4], increase appropriate help-seeking and provide benefits in terms of self-efficacy, self-esteem and morale [5].

Social relations may be measured using objective (or behavioral") indicators, such as the reported number of social contacts in a given interval of time [6–7] or subjective indicators, e.g. feelings of loneliness [8].

Severe mental disorders, such as psychotic and mood disorders may determine a risk of social isolation. For example, people experiencing persecutory delusions or auditory hallucinations may actively avoid social contacts [9–10]. People with high levels of negative symptoms or

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depression may experience lack of drive and motivation to social contacts [11–13].

Given the negative long-term consequences of social isolation, a number of supported socialization interventions have been developed to increase social relations of people with severe mental disorders [14–16].

An assessment of both subjective and objective indicators of social isolation in the two core groups of people with severe mental disorders, i.e. people with psychotic and mood disorders, may inform further development of such interventions. We focused our evaluation on: a) social contacts outside home, work environments and mental health services which are a focus of those socialization interventions [14–16]; b) feelings of loneliness, which may influence readiness of patients to participate in such interventions.

Identifying potential differences between patients with psychosis and mood disorders may help to assess whether there is a need for diagnosis-specific strategies to increasing patients' social relations.

This study aimed to: a) assess objective (number of social contacts outside home, work and mental health services) and subjective (feelings of loneliness) indicators of social relations in people with psychotic and mood disorders, defined according to the International Classification of Disease (ICD)-10 categories (F20–29 and F30–39) [17]; b) compare those indicators between the two groups.

Specifically our research questions were:

a) Is the number of social contacts outside home, work or care environments different between patients with psychotic disorders and those with mood disorders?
b) Are there any differences in subjective feelings of loneliness between these two patient groups?

2. Materials and methods

2.1. Sample

We assessed social contacts and feelings of loneliness in general adult psychiatry patients seen by two community mental health teams in the Newham borough of London. The study was exploratory and the variability of service users' responses to the questions was unknown. We estimated that a minimum of 30 patients per group would provide a sufficient estimate of the distribution of scores. Once we had recruited and interviewed 30 patients per diagnostic group, we stopped the recruitment.

Inclusion criteria were: 1) ICD-10 diagnosis of psychotic disorders (F20–29) or of mood disorders (F30–F39); 2) Age between 18 and 65 years; 3) Being in treatment with secondary care community services in the London borough of Newham (for which the mental health care provider is the East London NHS Foundation Trust); 4) Provision of informed consent for the participation in the study; 5) Absence of a cognitive deterioration that would make impossible for the patients to understand the interview questions.

All the steps of recruitment and the reasons for exclusion of the patients were documented in a recruitment flow diagram (Fig. 1).

The study has received a favorable opinion from the Ethics Sub-Committee of the East London NHS Foundation Trust.

2.2. Measures

a) *Number of social contacts*: Study participants were asked to list (without providing their names) all the people they had been in contact with in the previous week. Contacts in the workplace and in health care settings as well as people living with patients were excluded.

We chose to assess social contacts with reference to the previous week in order to minimize recall bias, but also to have a time interval large enough to ensure sensitivity in the assessment of patients' contacts.

We measured only social contacts occurring outside the home, the care setting or the workplace, as they might have made the total number of total social contacts difficult to interpret. For example, people living in large households, working in large teams, having more treating professionals and participating in group therapies would have had a higher number of contacts compared to those living alone, working in small teams, being in contact with a smaller number of professionals or receiving individual interventions. Yet, those contacts would not necessarily be considered by them as "social relations". Moreover, socialization interventions are usually focused to increase social networks of patients outside their home, workplace or health care services [14–16].

In case people from home/work/care environments were met outside of them (e.g. meeting fellow patients in a social occasion outside of the care environment) they were counted among the social contacts.

Feelings of loneliness: We assessed feelings of loneliness using the item 13.1 of the World Health Organization Quality of Life Assessment [18], i.e. "How alone do you feel in your life?" The item is rated on a Likert scale from 1 = not at all, to 5 = extremely.

We chose loneliness as a subjective measure rather than perceived social support as we were interested in a broader subjective perspective of social needs that goes beyond just receiving support from social contacts.

b) *Symptom levels*: Symptoms were assessed on the 24-item Brief Psychiatric Rating Scale [19]. This allowed computation of five BPRS subscales: 1) anxiety/depression (items: anxiety, guilt, depression, somatic); 2) thought disorders (items: thought content, conceptual disorganization, hallucinatory behavior, grandiosity); 3) negative symptoms (items: blunted affect, emotional withdrawal, motor retardation); 4) hostility (items: hostility, uncooperativeness, suspiciousness); and 5) activation (items: excitement, tension, mannerisms-posturing) [20].
c) *Socio-demographic and other clinical characteristics*: We collected socio-demographic and clinical