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How can social isolation be countered in an economic crisis?

Social isolation is a major risk factor for mortality and morbidity (Cacioppo and Hawkley, 2009; Holt-Lunstad et al., 2015; Smith et al., 2019). The excess risk of all-cause mortality due to social isolation has been reported to be 30–40% (Smith et al., 2019). The National Institute on Ageing (2019) suggests that social isolation is associated with a number of conditions, including hypertension, heart disease, obesity, and Alzheimer's disease. Moreover, social isolation is negative correlated with of numerous measures of mental ill-health, including severity of depressive symptoms (Lee et al., 2021), self-rated recovery following a crisis (Ma et al., 2021), and rates of suicide and alcohol abuse (Helliwell, 2007; Le et al., 2020). It is therefore unsurprising that a central tenet of rehabilitation psychiatry is the maximisation of social inclusion and community living (Killaspy et al., 2005). Social relationships are said to be a decisive factor in recovering from severe mental illness (Schön et al., 2009).

This essay will outline a number of measures which may be of use in counteracting social isolation, particularly in relation to rehabilitation psychiatry, while taking into account a number of the effects of economic crises. Two aspects of economic crises relevant to the provision of rehabilitation psychiatry and the experience of individuals with psychiatric needs will be examined: the economic and the social impacts. The economic impacts upon individuals will be considered first, followed by the economic impacts upon service providers. The impact of economic crises upon social cohesion and stability – and how this may in turn affect those with psychiatric needs in particular – will be considered last. Interventions with potential to mitigate social isolation will be offered in response to each impact of economic crisis.

Social Isolation

Before outlining strategies for countering social isolation, it is important to define what is meant by the term for the purposes of this essay. A scoping review found that the term 'social isolation' is ill-defined within the literature, with there being significant overlap between the concepts of social isolation and loneliness (Wang et al., 2017). Empirical research reports that the two are often not significantly correlated (Coyle and Dugan, 2012; Perissinotto and Covinsky, 2014), which suggests that they are independent constructs. Accordingly, the National Institute for Ageing (2019) promotes an understanding of social isolation which distinguishes between objective social isolation – the objective physical separation from other people (i.e. living alone) – and loneliness – the subjective distressed feeling of being alone or separated. Contrastingly, several researchers advocate for a definition of social isolation which includes reference to the quality of social relations, beyond the quantity or sheer existence of such relations (Nicholson Jr., 2009; Zavaleta et al., 2014). On this view, both objective social contact and subjectively perceived adequacy of contact are included within one overarching construct of social isolation.

For the purposes of this essay, interventions which aim to counteract both objective social isolation and loneliness will be included. Where an intervention is better suited to target one rather than both phenomena, it will be noted as such. This follows the advice of Holt-Lundstad and colleagues (2015) that efforts to mitigate risk of social isolation and loneliness

should consider both without the exclusion of the other. This view is influenced by the observation of Cacioppo and colleagues (Cacioppo et al., 2006, 2014) that the relationship between loneliness and social isolation is analogous, from an evolutionary perspective, to hunger and eating. On this view, loneliness is an adaptive signal that motivates one to alter behaviour in a way that will increase survival. The relevant point is that interventions which attempt to alter the signal (i.e. loneliness) without regard to the actual behaviour (i.e. social connection) and vice versa would likely be ineffective.

Effects of Economic Crises on Individual

Economic crises have large effects upon individuals throughout society irrespective of their mental wellbeing (Frasquilho et al., 2016; Gueorguieva et al., 2009; OECD, 2010; WHO, 2010). The limits of this essay preclude a fine-grained discussion of every effect; therefore a select few of particular relevance will be discussed. A key aspect of economic crises that affects individuals is higher levels of unemployment (Gueorguieva et al., 2009). A report by the International Labour Association (2015) into the effects of the economic crisis of 2008 found that in 2014 61 million fewer people were employed globally than there would have been had pre-crisis employment growth rates continued. For individuals in need of psychiatric rehabilitation, this trend is compounded by the fact that those with mental illnesses already suffer from high rates of unemployment (Dunn et al., 2008; Marwaha and Johnson, 2005; Pai et al., 2021; Social Exclusion Unit, 2004)

Unemployment can impact upon social isolation in numerous ways, ranging from the obvious to the underestimated. A clear consequence is a reduction in income (Gueorguieva et al., 2009; WHO, 2010). Lower income renders an individual less able to pay for goods and services which may compose elements of psychiatric rehabilitation and help ameliorate social isolation. The ability to travel to see family and friends, or socialise at events, restaurants etc., requires substantial disposable income. Psychiatric rehabilitation may be hampered without these elements. Beyond financial remuneration, employment provides other significant elements of rehabilitation. Indeed, employment is viewed by many rehabilitation psychiatry providers as crucial to recovery (Fioritti et al., 2014; Waddell and Burton, 2006). A qualitative study of individuals recovering from serious mental illness reported that employment fostered pride and self-esteem, provided coping strategies for psychiatric symptoms, and ultimately facilitated the process of recovery (Dunn et al., 2008). Most significantly, for the subject of this essay, becoming unemployed removes a source of social interaction. Employment provides a place to meet and bond with others (Waddell and Burton, 2006). It is clear, therefore, that restoring the employment status of individuals with psychiatric needs is beneficial for counteracting social isolation and encouraging rehabilitation.

Individual Placement and Support (IPS) is a psychosocial intervention which may be a viable and effective way of counteracting the social isolation which will emerge as a result of rising unemployment. IPS is a systematic approach to helping individuals with severe mental illness achieve competitive employment (Becker and Drake, 2003). It provides intensive support to help individuals search for, attain, and succeed in work (Royal College of Psychiatrists, n.d.). The service also seeks to integrate working life with mental health services, so that individuals remain supported whilst working. Systematic reviews have

consistently found that IPS significantly increases the competitive employment rate of individuals compared to control (Bond et al., 2012, 2008; Wallstroem et al., 2021). Moreover, a large randomised control trial showed that total costs for IPS were generally lower than standard services over first 6 months (Burns and Catty, 2008). Improving access to work using IPS may ameliorate the social isolation brought about by unemployment by restoring the social environment of the workplace.

Another aspect of economic crises to consider here is how government fiscal policy can be harnessed in conjunction with IPS. A typical response of governments to an economic crisis is to increase spending in order to stimulate the economy. For example, following the economic crisis of 2008 the United States passed the American Recovery and Reinvestment Act, which provided roughly $830 billion to the economy in the form of tax cuts and spending measures (Center on Budget and Policy Priorities, 2016). Similar fiscal strategies were used in response to the COVID-19 pandemic, where governments increased spending in order to stimulate growth and avoid further economic turmoil (IMF Fiscal Affairs Department, 2021). Such measures may be used to helping individuals gain employment: one example of this is the Lifetime Skills Guarantee announced by the UK government in 2020 in response to the COVID-19 crisis. The scheme provides free training courses to individuals to aid them gain skills and further employment (Department of Education, 2021). It may be beneficial to combine government schemes like the Lifetime Skills Guarantee with pre-existing measures like IPS in order to improve the professional prospects of those who are socially isolated.

One potential barrier to successful implementation of the measures outlined above is the competition individuals with mental illness may face from those without mental illness – particularly at a time when overall job availability has fallen as a result of an economic crisis. A viable alternative to paid employment to consider is volunteering.

Volunteering is defined as an activity that involves spending time, unpaid, doing something that aims to benefit the environment or individuals or groups (Meta, 2009, p. 3). Volunteerism encompasses a variety of both online and offline activities, ranging from providing emotional support through helpline services to environmental and conservation work (Mak et al., 2022). Research has shown that supported volunteering is a viable and useful way of helping individuals with severe mental health conditions to recover (Fegan and Cook, 2014). Volunteering has been shown to confer numerous benefits with regards to physical and mental wellbeing (Black and Living, 2004; Fegan and Cook, 2014). With respect to social isolation in particular, volunteering can be a form of positive social engagement: studies have shown that volunteering can lead to an increased sense of belonging and involvement for individuals excluded from other social spheres (Bashir et al., 2013; Hill, 2009). Importantly, volunteering schemes offer not only spaces for social interaction – thus ameliorating objective social isolation – but also the opportunity for quality interactions – thus potentially remedying loneliness. That volunteering aims to benefit others is the important point here: an environment is created in which individuals come together with a shared goal, thus fostering a united spirit that may give rise to the right conditions for authentic, quality human connection – over and above the simple existence of human interaction. Thus volunteering may ameliorate not only objective social isolation but loneliness too.

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One example of volunteering is of particular relevance to those recovering from mental illness: peer support. Peer support is when people with experience of mental distress support another experiencing similar difficulties by utilising their own lived experience as a tool for support (Beales and Wilson, 2015). Peer support has been integrated into mental services globally and has been shown to be effective (Mahlke et al., 2014). Volunteering or indeed working in peer support may be of particular use in addressing social isolation because it gives individuals an opportunity to work within mental health services that they themselves may have been recipients of. The significance of this is that it may provide an opportunity to transform a patient–professional relationship into one of co-workers. This may reduce the impact of power dynamics or paternalistic relationships and lead to greater quality of relationship – and thus counteracting subjective and objective social isolation.

Effects of Economic Crises on Service Provision

Economic crises significantly impact upon government spending. Many countries responded to the 2008 crisis by imposing austerity measures (Armingeon and Sacchi, 2022). This has significantly affected mental health service provision (Maresso et al., 2014; McDaid et al., 2013; Thomson et al., 2015). Cuts to funding mean that service providers are able to employ fewer staff members and deliver fewer treatments. Existing services are also stretched: the demand for psychiatric services increased following the 2008 crisis (Faculty of Public Health, n.d.). As a result, interventions which are more affordable to service providers are likely to be useful. One intervention with potential to counteract social isolation while saving service providers funding is computerised cognitive behavioural therapy (C-CBT).

Cognitive behavioural therapy (CBT) is a psychological intervention which seeks to teach individuals to recognise their own autonomic thoughts and to regard them as hypotheses to be tested rather than as facts (Rook and Peplau, 1982). It seeks to change how individuals feel towards situations by changing the way they interpret events. It has been suggested that those experiencing social isolation and loneliness suffer from certain negative cognitive biases which affect their social skills (Cacioppo and Hawkley, 2009; Young, 1982). Cacioppo and Hawkley (2009) suggest this is because feelings of social isolation trigger implicit hypervigilance for social threats which introduces attentional, confirmatory, and memorial biases. Empirical studies support this theory: one study has found that lonely individuals have a higher tendency to form negative social impressions of others than non-lonely individuals (Cacioppo and Hawkley, 2005). This suggests that interventions which remedy these biased perceptions can break the cycle of negativity that people experience when lonely (Masi et al., 2010; Smith et al., 2021; Young, 1982). A meta-analysis of interventions to reduce loneliness found the most successful interventions to be those that addressed maladaptive social cognition (Masi et al., 2010). A more recent systematic review found some evidence that perceived social support may be improved by interventions that involve cognitive modification, though this was based upon a small number of mainly small trials (Ma et al., 2020). Interestingly, the same systematic review found that cognitive modification was not effective in addressing objective social isolation. This is understandable, given that cognitive therapies seek to address individual (i.e. subjective) comprehension of events. Thus, CBT is most useful in counteracting subjective social isolation.

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With regards to economic crises and reduced service provision, the crucial caveat to implementation of CBT for social isolation is the use of a computerised version. C-CBT is a version of CBT which is delivered online. Systematic reviews have shown that C-CBT is effective in managing numerous mental health disorders (Grist and Cavanagh, 2013; Hedman et al., 2012; Kaltenthaler et al., 2008), including but not limited to depression (Vallury et al., 2015; Wright et al., 2022), anxiety (Christensen et al., 2014; Mayo-Wilson and Montgomery, 2013) and social anxiety (Williams et al., 2014). Reviews have found that C-CBT is as effective as regular CBT (Hedman et al., 2012). Crucial to the subject of this essay is the fact that C-CBT is significantly cheaper to deliver than CBT (Thase et al., 2020). Thase and colleagues (2020) report that C-CBT costs $945 less per patient compared to CBT. To put this into the UK context, take the Office for National Statistics (2018) report that 6% of adults report feeling lonely always or often; the potential savings to mental health spending accrued as a result of using C-CBT over CBT to address the social isolation of all UK adults would be over £2.2 billion. C-CBT also has significant cost-reducing features for individuals as transportation costs are eliminated. For these reasons, C-CBT may be a useful way of counteracting social isolation in an economic crisis.

Effects of Economic Crises Upon Social Cohesion

The effects of economic crises are not only financial in nature. Economic crises have social consequences; they can cause the relations between groups in society to fracture. Reports globally have found that overall social cohesion fell as a result of the economic crisis of 2008 (Teyssedre and Le Bouler, 2019). It has been suggested that this translates to decreased public empathy toward the needy (Direction Générale de la Cohésion Sociale, 2017), including those with mental illness. Those with psychiatric needs are at risk of stigmatisation and rejection in times of crisis as public resources are squeezed and services are prioritised over others: reports indicate that mental health services are given low priority in terms of safeguarding services in the face of budget cuts (Matschinger and Angermeyer, 2004; Schomerus et al., 2006). Dietrich and colleagues (2004) argue that people's attitudes toward the allocation of financial resources function as an indicator for the acceptance of structural discrimination – structural discrimination being one manifestation of stigma. It therefore seems plausible that economic crises may lead to increased stigmatisation of those in need of psychiatric rehabilitation. Stigma is already a major reason for individuals not seeking help for mental health problems (Henderson et al., 2013). If economic crises worsen the stigmatisation of individuals with psychiatric needs, it is likely that their isolation will worsen as fewer numbers seek help. Interventions which address stigma may therefore be of use in counteracting social isolation.

Stigma is defined as an attribute or trait that marks an individual as being unacceptably different from the “normal” people with whom he or she routinely interacts (Scambler, 1998). Evidence consistently reports that the public hold strongly negative attitudes towards people with mental health problems (McDaid, 2008). This stigma can lead to individuals with psychiatric needs delaying or even avoiding getting help (Hanisch et al., 2016; Henderson et al., 2013; McDaid, 2008), which can worsen social isolation. Interventions which aim to address stigma have shown mixed efficacy (Hanisch et al., 2016). The most

effective interventions are targeted campaigns for specific groups, such as schoolchildren, police and healthcare staff, as opposed to general anti-stigma campaigns (McDaid, 2008).

One targeted intervention of particular relevance here is direct social contact. This approach seeks to dispel inaccurate and negative beliefs about mental illness by placing people in direct personal contact with the stigmatized group (Couture and Penn, 2003). Contact has been shown to be effective in reducing the stigmatization of persons with mental illness in both retrospective and prospective studies (Couture and Penn, 2003). Importantly, contact offers individuals experiencing social isolation a means to paid or unpaid employment which may address social isolation. Moreover, the need for honesty and intimacy between those delivering and participating in these sessions may foster an opportunity for quality interactions to bloom and for loneliness to wither away. By combatting stigma, which may be heightened as a result of economic crisis, individuals may experience less social isolation.

Conclusion

In this essay I have outlined three approaches to counteracting social isolation in an economic crisis. I have argued that supported employment and volunteering programmes may be useful in mitigating the effects of an economic crisis upon individuals. I have argued that computerised CBT may be of use to service providers. Finally, I have argued that programmes which tackle stigma against individuals with mental illness may be useful, particularly where economic crises may have worsened such stigma. To conclude, although an economic crisis will undoubtedly stress individuals, service providers, and society at large, there remain viable options to counteracting social isolation.

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