Quality in Ageing and Older Adults

Title: ‘On their own’ social isolation, loneliness and chronic musculoskeletal pain in older adults

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ABSTRACT

Purpose: In this paper, the concepts of social isolation and loneliness will be explored in relation to people with chronic musculoskeletal pain. Through this, biological, psychological and social factors will be examined to consider how we can identify people at risk of social isolation and loneliness who have chronic musculoskeletal pain and secondly how health professionals may intervene to reduce their effects.

Design/methodology/approach: Conceptual paper.

Findings: Social isolation and loneliness is evident in people with chronic musculoskeletal diseases. This may be bi-directional where both pain may lead to social isolation and loneliness, or social isolation and loneliness may exacerbate pain. Interventions to improve the symptoms of chronic musculoskeletal pain, and approaches around social participation and engagement should be adopted in combination to ameliorate this potentially disabling scenario.

Originality/value: There remains limited evidence around the prevalence and management of social isolation and loneliness for people with chronic musculoskeletal pain. By raising awareness of social isolation and loneliness in this population, people with chronic musculoskeletal pain may be better supported to reduce the negative impact that social isolation and loneliness can have on their health and well-being.

KEYWORDS: Musculoskeletal; Arthritis; Loneliness; Isolation; Morbidity; Depression; Rheumatology
INTRODUCTION

Chronic musculoskeletal pain is a major cause of functional impairment, disability and reduced quality of life for older adults (Moradi-Lakeh et al., 2017). Whilst previous literature has acknowledged an association between social isolation and pain, there remains limited discussion on how it may be tackled. In this paper, we will further explore the concepts around social isolation and loneliness for this specific group of older adults, and consider what could be done to mitigate the adverse effects associated with these on health and well-being.

Musculoskeletal pain older adults

Chronic musculoskeletal pain, a condition characterised by pain, joint stiffness, disability, functional impairment and reduced quality of life (Lee et al., 2015). It is a major health burden across all age groups (Mody and Brooks, 2012). The prevalence of chronic musculoskeletal pain has been reported as 66% in those over 65 years (Elliott et al., 1999) and higher for those aged 80 years and above (Lonser, 2010). There has been an increase in population ageing in most countries, with the fastest growing group being those over 80 years (Abdulla et al., 2013). Chronic musculoskeletal pain is multifactorial, being associated with physical and psychosocial difficulties (Beneitez and Nieto, 2017). Despite considerable research undertaken during the past 20 years on the diagnosis and treatment of chronic musculoskeletal pain, there remains poor understanding on its effective treatment with pharmacological and non-pharmacological interventions (Ojala et al., 2015).

Social isolation and loneliness

Social isolation is the lack of meaningful and sustained communication or interaction with friends, family and the wider community (Wenger et al, 1996). Loneliness refers to the subjective feeling of being alone or apart from other people (Ernst and Cacioppo, 1999). It is a balance between desired and actual social contact (Ernst and Cacioppo, 1999). Whilst social isolation and loneliness are interrelated, each reflect a different concept (Routasalo et al., 2006). Examples of social participation can include charity/volunteer work, attending sports/social clubs, educational/training courses or joining political/community organisations. It has been estimated that approximately five percent of older people in England are categorised as ‘completely’ isolated (Shankar et al., 2013).
Social isolation and loneliness are associated with a negative self-assessment of health and well-being in older adults (Golden et al., 2009; Landeiro et al., 2016; Tvis et al., 2011). This can result in adverse health outcomes including poor physical and mental health, maladaptive behaviours and an increased likelihood of institutionalisation (Luanaigh and Lawlor, 2008; Courtin and Knapp, 2015). It is associated with increased emergency department admissions and greater length of hospital stay (Landeiro et al., 2016; Lim et al., 2006). People who report being socially isolated or lonely also report less exercise participation, greater tobacco use and have a greater number of long-term medical conditions compared to those with greater social participation behaviours (Golden et al., 2009; Landeiro et al., 2016).

**Impact of Social Isolation and Loneliness for People with Musculoskeletal Pain**

The principal symptoms of musculoskeletal pain are pain, muscle atrophy, fatigue and associated anxiety and depression (Veronese et al., 2016). The consequences of this are reduced independence, decreased functional capability, and consequentially, a reduction in quality of life. It is therefore no surprise that previous research have demonstrated the increase in social isolation and loneliness through chronic musculoskeletal pain (Wolf and Davis, 2014; Chan et al., 2014; Jaremka et al., 2014). There is also potential reverse causation where: (1) pain may lead to social isolation and loneliness through disability, but also (2) social isolation and loneliness may increase the opportunity for rumination and negative thinking about pain, to increase pain perception (Wolf et al., 2015; Jaremka et al., 2014). Through this, pain, social isolation and loneliness may spiral in the absence of support and intervention.

In a similar way to frailty, musculoskeletal pain can reduce an individual’s actual or perceived capability for physically engagement in society and pre-existing social networks. Musculoskeletal pain management and support to foster improved physical activity behaviours can enable an increase in an individual’s social engagement (Robins et al., 2016). However, for those with debilitating symptoms which are challenging to manage, technological advances through telecommunications and social media have allowed people to interact with previous or new social networks (Petersen et al., 2016; Gao et al., 2016; Webber and Fendt-Newlin, 2017).

By increasing social engagement and decreasing loneliness through whatever means, people with chronic musculoskeletal pain can have a significant improvement in physical and mental health (Sturgeon and Zautra, 2016). Parrish et al. (2008) reported that increasing interpersonal events had a significant improvement in fatigue associated with musculoskeletal pain. Furthermore the positive effects of social engagement programmes have on physical and mental health and reducing
institutionalisation, emergency department admissions and hospital length of stay when people are admitted (Gardiner et al., 2016; Dicken et al., 2011), are particularly important on wider health challenges which older adults face (Luanaigh and Lawlor, 2008; Courtin and Knapp, 2015; Lim et al., 2006).

Interventions

There are a wide range of interventions which have been developed to address social isolation and loneliness for older adults (Gardiner et al., 2016). These have included community development interventions and groups, home visits, buddy systems and internet training (Dicken et al., 2011). Whilst these appear to be effective, no one particular model has been shown to be ‘optimal’ for older adults nor specifically for those with chronic musculoskeletal pain.

More recently, there is a growing body of evidence around ‘acceptance-based’ pain management programmes (Mathias et al., 2014). These include treatment approaches such as acceptance and commitment therapy, mindfulness and contextual cognitive behaviour therapy (Mathias et al., 2014; McCracken and Vowles, 2014). People with chronic musculoskeletal pain conceptualise and hold different meanings of acceptance of pain and symptoms (Biguet et al., 2016). By tailoring social integration and activity programmes around loneliness and isolation, acknowledging people’s acceptance to their chronic pain states, such activity programmes may be more sustainable for older adults. These cognitive approaches may be valuable for individuals to consider when planning and goal-setting activities to address social isolation and loneliness. Furthermore, there is an evidence-base around internet-delivered acceptance and commitment therapy for those with severe physical disability associated with chronic pain disorders (Buhrman et al., 2013). Through this, those who are limited in their physical function, those with reduced access to transport and those who are geographically isolated may then have greater opportunities to gain help whilst developing new networks to mitigate the negative effects of social isolation and loneliness.

Recommendations

Social isolation and loneliness are health challenges faced by older adults. Those who have chronic musculoskeletal pain have a greater risk of being socially isolated or lonely. Symptom management (principally pain, muscle atrophy, fatigue and depressive symptoms with disability and functional impairment) is important to facilitate greater physical activity and consequential social engagement. However this may not be sufficient, and further support to intervene in addressing these problems may be warranted. Such interventions should be tailored, not only to an individual’s desires and goals towards socially engagement, but to how social isolation relates to their personal
musculoskeletal pain experiences and beliefs. Whilst such strategies may be costly to both health and social care services (Husk et al., 2016; Mossabir et al., 2015), this may be offset through reduced health and service care burden in accident and emergency admissions, formal and informal carer costs and reduced primary and secondary care utilizations (Husk et al., 2016; Landeiro et al., 2016; Lim et al., 2006; Mossabir et al., 2015). Through this, biopsychosocial features of an individual’s disease can be sufficiently addressed for sustainable improvements in symptom management and social engagement. The development and testing of such a tailored social engagement intervention with a pain management component is a research priority. This should be evaluated through quality of life, pain and symptom control outcomes, in addition to both health economic measures and assessment tools to estimate social isolation (i.e. Lubben Social Network Scale (Lunnen and Gironda, 2000) or the Berkman-Syme Social Network Index (Berkman and Syme, 1979)) and loneliness (i.e. Revised University of California, Los Angeles (UCLA) Loneliness Scale (Hughes et al., 2004). Following this, healthcare professionals may be ‘armed’ with an evidenced-based intervention to improve outcomes for this population who have previously been largely under/un-researched.

**CONCLUSIONS**

Placing social isolation and loneliness on the ‘radar’ of healthcare professionals, and providing a stronger evidence-base on-which to make clinical judgements, are the first steps in providing better care for older adults with chronic musculoskeletal pain. Given the significant health consequences of social isolation and loneliness on older adults, and the high prevalence of chronic musculoskeletal pain in this population, such a health challenge should not be overlooked.
REFERENCES


