‘Oh no, not a group!’ The factors that lonely or isolated people report as barriers to joining groups for health and well-being

Avelie Stuart1*, Clifford Stevenson2, Miriam Koschate1, Jessica Cohen3 and Mark Levine1,4

1University of Exeter, Psychology, UK
2Nottingham Trent University, Psychology, UK
3Age UK Exeter, UK
4Lancaster University, Psychology, UK

Objectives. Belonging to groups can significantly affect people’s health and well-being for the better (‘the social cure’) or worse (‘the social curse’). Encouraging people to join groups is a central component of the Social Prescribing movement; however, not everyone who might benefit from Social Prescribing aspires to participating in groups. This study aims to identify what barriers are preventing people from experiencing the associated health and well-being benefits of group belonging.

Method. Semi-structured interviews analysed using reflexive thematic analysis. Participants were 11 white British people (aged 48-86), 1 male and 10 female, recruited by a charity partner of a Social Prescribing project.

Results. The themes derived from the interviews are as follows: (1) ‘The dread, the fear of being in a group’: When groups do not meet needs; (2) ‘I can remember as quite a young child backing out of things’: Accumulative barriers over the lifetime, and (3) ‘I’m singing away and feeling terribly miserable’: the challenges of fitting in with others in groups. The themes reflect how people can feel deterred from social interaction, which interferes with their ability to derive a sense of belonging or shared identity associated with the ‘social cure’.

Conclusions. A key challenge for Social Prescribing is to meet the social needs of people disinclined to join groups; groups can be detrimental to health and well-being if there are barriers to integration. Alternative ways of structuring groups or activities may be more effective and can still avail of the belonging and identity associated with ‘the social cure’.

Statement of contribution

What is already known on this subject?

• Frequent attenders at primary healthcare services often have unmet social needs.
• Loneliness is detrimental to health and well-being; poor health also increases loneliness.
Social Prescribing programmes can help individuals find group belonging and reduce loneliness.

What does this study add?

- Identifies factors preventing people from benefitting from Social Prescribing.
- Shows that lonely people should be matched with groups/activities that meet their particular needs.
- Affirms that Social Prescribing will benefit from adhering to theory on how groups improve health.

Background

People with rich social lives are happier and healthier than people who are lonely or isolated (Glei et al., 2005; Greenaway, Cruwys, Haslam, & Jetten, 2016; Haslam, McMahon, et al., 2018; Holt-Lunstad, Smith, & Layton, 2010). Indeed, maintaining positive social connections is as important for our health as physical exercise or quitting smoking, yet the general public and the medical professions have traditionally undervalued social connectedness in relation to health (Haslam, McMahon, et al., 2018). This view is changing – loneliness and its detrimental health effects have made headlines across the UK in recent years, becoming part of the national conversation (e.g. BBC, 2019; Campaign to End Loneliness, 2019; Jo Cox Foundation, 2016). In 2018, the UK government published their first strategy on loneliness – announcing commitments to Social Prescribing connector schemes aimed at reducing and/or preventing loneliness and helping people feel more connected to others (GOV.UK, 2018).

Social Prescribing schemes are underpinned by the recognition that frequent attenders at primary healthcare services have unmet social needs which may be better supported within community settings (GOV.UK, 2018; Haslam, Haslam, & Cruwys, 2019). The idea of supporting health through community or group-based settings is backed by evidence from ‘the social cure’ literature (e.g. Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018; Häusser, Junker, & van Dick, 2020; Jetten, Haslam, & Haslam, 2012; Kellezi, Wakefield, et al., 2019).

Our interview study was conducted within this context, with a particular concern in mind: that not everyone is readily amenable to community or group-based programmes (e.g. one project reported 63–88% take-up, Kimberlee, 2013), and that efforts to put lonely people into groups, without the components in place for scaffolding social support (see Haslam et al., 2019), may be counterproductive as lonely people tend to experience high levels of social anxiety (Lim, Rodebaugh, Zephyr, & Gleeson, 2016). Research investigating or addressing non-participation (including non-attendance and attrition) from social and health programmes is scarce (Dare et al., 2019; Kimberlee, 2013; Normansell et al., 2016). Hence, this study targets an important subpopulation of people who may be missing out on the benefits of Social Prescribing.

Social prescribing and why people are being encouraged to join groups

Social Prescribing entails a holistic approach of transitioning clients from clinical to non-clinical community support, by referring them to a practitioner who can co-develop and support an individual to take control of their own health care, including their social health (Kellezi, Wakefield, et al., 2019; Kimberlee, 2013). Although there are positive reports about Social Prescribing, it is more complex than prescribing other health determinants such as exercise (Haslam, McMahon, et al., 2018). Social Prescribing has been developed as a bottom-up practice, based on identified gaps in health/social services, with a need for theory/s to understand the mechanisms that lead to any positive outcomes (Stevenson et al., 2019).
One such theory that is gaining a strong evidence base is the social identity approach to health (referred to as ‘the social cure’, Haslam, McMahon, et al., 2018; Jetten et al., 2012). Social cure researchers emphasize the role of groups in social connectedness and health, because groups tend to demonstrate superior benefits over time compared to individual relationships (Glei et al., 2005). Cruwys, Wakefield, Sani, Dingle, and Jetten (2018) found that the number of important group memberships people possess relates to lower primary care attendance even when controlling for known demographic factors, physical health and medication.

Group memberships form part of how we see ourselves (our identities) and give us a basis for a positive self-concept, which enables the experience of belonging, self-esteem, control, meaningful existence (Greenaway et al., 2016) and opportunities to ‘give back’ to others (Steffens, Cruwys, Haslam, Jetten, & Haslam, 2016a; Steffens, Jetten, Haslam, Cruwys, & Haslam, 2016b; Wentowski, 1981). Having more group memberships is usually better – as the number of important group memberships individuals hold enables resilience through life changes (Steffens, Jetten, et al., 2016), such as the loss of friends, or retirement from work (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009; Jetten et al., 2015; Jetten, Haslam, Iyer, & Haslam, 2009). The social cure effect applies across many types of groups (e.g. work groups, activity/hobby groups and social categories such as gender), so long as these groups hold value for the individuals themselves, and that people define their self as being a member of that group.

There is, however, also a dark side to group memberships referred to as ‘the social curse’ – whereby groups damage people’s health if the group fails to sufficiently support or include its members or if the group norms are unhealthy (DeMarco & Newheiser, 2019; Haslam, Reicher, & Levine, 2012; Wakefield, Bowe, Kellezi, McNamara, & Stevenson, 2019). When group memberships become burdensome, they can increase feelings of isolation (Kellezi, Bowe, Wakefield, McNamara, & Bosworth, 2019), and incompatible group memberships can cause tension and prevent integration into new groups (Matschke & Fehr, 2015).

To experience the social cure and avoid the social curse, individuals must have the capacity to be able to (come to) see themselves as similar to each other, or as sharing the same identity as other group members; joining a group and socializing with other people is not sufficient and can prevent the intended health or psychological benefits (Cruwys et al., 2020; Jetten et al., 2012). Furthermore, groups must develop from ‘the ground up’ and have ownership of their activities; imposed activities or values will interfere with members’ development of a shared identity (Haslam et al., 2019). In the case of using group programmes to combat loneliness, due to the close relationship between chronic loneliness and social anxiety (Lim et al., 2016), organizers may also need to take particular care to address anxieties in order for participants to trust each other (see Tarrant et al., 2016).

Despite the centrality of these considerations, there is little if any research on why individuals might not wish to join groups or what the barriers might be to availing of group benefits. Given the increased recognition of the importance of loneliness reduction for health, and the pivotal role of community groups in providing this, research into the potential obstacles to group-based interventions has never been more important.

**Current study**

This study was part of a larger project with Age UK Exeter, a charity for older people that provides support and social activities, thus the focus on a mainly older sample in study
recruitment. Age UK Exeter are partners in a large Social Prescribing project (Wellbeing Exeter) and had independently identified a need to broaden their client base by gaining insight from people who do not attend their day sessions or groups. Accordingly, the research set out to recruit and engage a unique, previously overlooked, and potentially vulnerable sample (Dare et al., 2019; Ellard-Gray, Jeffrey, Choubak, & Crann, 2015) – at risk from social isolation and loneliness but resistant to group-based social inclusion.

This interview study engages participants in reflection on what the barriers to their participation in groups might be and where these derive from. The aim of the research is to identify the common barriers preventing people from joining and finding belonging in groups, and to make recommendations as to how Social Prescribing initiatives can successfully deliver the necessary aspects underpinning the social cure effect – namely providing opportunities for the development of shared identities in groups.

**Method**

**Participants**

Of the 58 people deemed eligible, 29 provided contact details, and due to unavailability/declines (and shortness of time and funding) we had a final interview sample of 11 middle aged and older people (range: 48–86). All participants except one were female, and all were white British. Three participants were in fulltime employment, the others were retired or on benefits (for health/disability reasons). Two participants said their health was not good, and three did not report their health, while the others reported good or fairly good health.

**Procedure**

After obtaining ethical approval from the University of Exeter Psychology Ethics Committee, an Age UK Exeter employee conducted participant recruitment (from December 2018-May 2019) through community networks, by setting up a stall in a library, visiting a dog-walking park, and visiting community garden allotments. People approached were asked if they ‘like socializing in groups’ and if they consider themselves someone who ‘doesn’t join groups’. If they disagreed with the first question, and agreed with the second, and were in the relevant age group (middle to older aged), they were invited to interview – first with the Age UK Exeter employee, and then with the first author of this paper. This partnership with Age UK Exeter facilitated the recruitment but also the engendering of trust in the researchers.

The research interviews generally took place in participant’s homes or in a public library, except one interview by phone. We obtained informed consent and then interviews proceeded, lasting on average 48.5 min (range 30–91). Participants were free to withdraw or not answer particular questions. There was no remuneration for participation.

**Materials**

The interview questions (see Appendix) were semi-structured and adapted to participants’ responses. The definition of groups given to participants was: ‘When I talk about groups I mean this very broadly – it could be friendship groups, activity groups, work groups, churches or religious communities, committees and volunteering, neighbourhoods or even extended family may feel like a group to you.’
Participants were asked about their current group memberships, if any, and whether they would like to join any groups. They were asked about experiences of being in groups – particularly any negative experiences. We asked questions about giving feedback to group organizers, the need to belong (to people, places, or other), and whether they have different times in their life when they feel like connecting to others, either one-on-one or in groups. We did not specifically talk about loneliness as it is a stigmatized topic (Campaign to End Loneliness, 2019; Dare et al., 2019; Rook, 1984); however, we did ask whether or not they felt a desire for greater social connections.

**Data analysis**

A professional service transcribed the audio files, and then the first author went through each transcript with the audio playing to correct mistakes and anonymise confidential details. This helped with familiarization. The analysis was guided by reflexive thematic analysis (Braun & Clarke, 2006, 2019), which is a way of identifying common meaning across a dataset. The first author conducted coding in NVivo12, in discussion with the other authors (AS, CS, MK, ML discussed themes in relation to theory and related research, and with JC we discussed themes in relation to current applied practice). The coding included the whole dataset and all reasons for not joining groups. After the initial coding, we merged repetitive or similar codes and grouped them under broad categories. Although the aim was to identify the most commonly occurring barriers, it became apparent unique perspectives existed; thus, in the results we strike a balance between retaining individual voices while organizing common themes. Real names are not used in the given quotes. The analysis is thus inductive/bottom-up; connections to theory are made in the discussion. Participants’ responses were treated as a real reflection of their internal thoughts and experiences, and we only describe participants’ psychological states in terms they used themselves – thus adopting a realist, semantic style of thematic analysis (Braun & Clarke, 2006).

Demographically, the authors are similar to the participants (although younger on average), which would likely have minimized any cultural differences in understandings. Anonymised transcripts are privately stored on figshare and can be requested from the corresponding author.

**Results**

We derived the following higher order themes from the coding. (1) ‘The dread, the fear of being in a group’: When groups do not meet needs, (2) ‘I can remember as quite a young child backing out of things’: Accumulative barriers over the lifetime, and (3) ‘I’m singing away and feeling terribly miserable’: the challenges of fitting in with others in groups.

*The dread, the fear of being in a group*: When groups do not meet needs

Some participants expressed the view that they never wanted to join any groups, but felt obligated to join them. The first example is June (Female, late 50s, widow, on benefits for mental health reasons), who was experiencing grief and anxiety after her husband committed suicide. She listed a range of therapies, counselling, community cafes and interest groups that she has approached or had suggested to her. Her GP apparently told her that ‘if you join a group, everything will be fine’, and ‘there’s lots of help in the...
community’ – but when she tried to follow up felt that people let her down, or that their suggestions were not suitable. In particular, she does not see the point of groups:

I know there’s this research - that it’s good for you to be in a group, but I don’t know. Is it? . . . it does make you think: oh no, not a group!

. . .

There was a lady that came you know from some kind of health thing. She thought I might have kind of autism, or something. She went through, you know a long list of things and she said, “oh, we can- you know we can get you diagnosed at some stage if you’d like that? There’s a two-year waiting list”, or something. “And, then you can join a support group for it!” And I thought, NO! There’s no point. If you were that – if you were just going to be told to join a support group for it you know. Because, that’s what you don’t want to do.

June’s statement implies common knowledge that ‘joining a group is what you don’t want to do’. Throughout the interview, we unpacked the meaning of this sentiment. Given her life circumstances, she said she dreads the prospect of interacting with others – for example when people ask her about family and she has to explain that she has none, other people become awkward around her; when she has to complete a task for the group (such as reading for a book club), she becomes anxious. Even the idea of befriending was unappealing to her:

Well, I haven’t tried it [befriending], but I don’t think – why? Why am I going through all this stress of – and worry about it and, and, and. You know? I know I’ve got – I do have anxiety, but, I’m also worrying about the other person and they’re not really wanting to meet me. And, they’re doing it – because, I did, I did become sort of friends with this lady, and her son had died of a brain tumour when he was at University I think, and I was going out of my way to be kind and seeing her and doing activities she wanted to do – meeting her for coffee and she was doing the same for me – we were both hating it.

This quote illustrates that putting people together based on what appears to be a similar experience is not always sufficient for being able to relate to each other. For June, befriending or joining groups felt obligatory, and in opposition to her own needs. The need that she did express was for formal mental healthcare, and she expressed frustration at her GP for putting emphasis on finding help in the community.

A second example is Celia (Female, late 40s, has Myalgic Encephalomyelitis) who has been encouraged by her GP to attend several group-based ME support sessions which she attended faithfully but did not find beneficial. She finds being around people exhausting and feels a constant sense of tension, even in small informal groups:

Yeah, well, I don’t even really do small groups. Like when we finished the widespread pain clinic and there was only like four of us, or five of us that decided we were going to meet up for coffee every couple of weeks. And, even that, just going for a coffee with four people was just too much. It’s just. I would walk into the place with dread because I’ve got to be around people and knowing that it’s going to wear me out and it was just going to be like I can’t do anything else now for myself.

. . . I thought about doing, going to like laughing yoga, or something, just to try and get me out of the house. But, again, I just- the dread, the fear of being in a group of lots of people is just like I can’t do that.
As shown in this extract, Celia has attempted to stay in touch with groups (she also mentioned a craft group), but all of them made her feel worse. Barriers ranged from having to deal with fatigue and pain (i.e. key symptoms of ME), dread at the thought of being around people and feeling as if attending groups are a purely external obligation without self-benefit. She also later expressed the view that sharing ideas with peers is ineffective if the group is imbalanced by particularly dominant individuals (an issue mentioned by most participants):

I get why they do it, because like with the others, they say you’re in a room, you’re in a place with people who have got the same ideas, goals, situations and health problems, you can share umm your experiences and learn from each other. And, I get why they do that. But, if you’ve got one person talking the entire time and nobody else says anything, you’re not actually learning, or sharing anything. You’re just sitting there listening to someone talk. So, that defeats the object.

Although this quote could be interpreted to mean that better group facilitation, encouraging equal participation would address the issue, in her case she says she does not want to be heard. She does not want encouragement to speak up, nor to be more included:

I would rather just shrink into the corner and let everybody do their thing. And, then . . . you know, as long as I’m not heard and not seen I’m fine.

Thus, for Celia, the only desirable solution is that people leave her to manage her health condition on her own. She finds it hard to say no to people, especially her GP, who she felt does not take her medical problems seriously. She expressed a feeling of knowledge that she should be joining groups, on the advice of her health practitioners, but says that this has been to the detriment of her health management. Thus, we see that for some people, further encouragement to join groups is unwelcome.

‘I can remember as quite a young child backing out of things’: Accumulative barriers over the lifetime

Although we did not ask about their childhood, some participants referenced their early life experiences as shaping their current lack of belonging to groups, a well-known factor of loneliness in later life (Duncan & Bell, 2015). Notably, some interviewees who talked about past traumas said they avoided group settings because they are too uncomfortable, whereas others talked about feeling like an outsider, unable to penetrate into social life.

For example, Emma (Female in her 80s, lives alone) had heard the messages about groups being good for your health, but said that it is ‘easier said than done’. Despite having joined dozens of groups in the last couple of years, she described a persistent feeling of being an outsider:

I always feel as if I’m outside looking in. And, I seem to remember that when I was quite young – that I was outside, looking in.

Emma attributed this feeling to enduring personal and social barriers including shyness, health problems as a child where she missed out on many experiences, and also on socio-economic disadvantage – a feeling that has persisted in college, her working life, and still now in her 80s where she feels like the only ‘benefits person’ at groups she
attends. She also finds larger social groups cliquey. Most of all Emma wanted to continue with a walking group and described herself as a ‘caged tiger’ who does not feel at home in enclosed spaces – however, physical health problems prevent her from doing so.

Similarly, Eleanor (Female in her late 80s, divorced) has post-polio syndrome and needs a walking frame, so she cannot do many outdoor activities; however, she also finds it uncomfortable to be in crowded rooms. She attributed this feeling to her childhood experiences:

Well, I find I sort of need to... sit a little distance away. Sometimes quite near a door. Which, unless people are aware of the mental health thing, they sort of assume you’re being standoffish. Yeah, I can’t go and sit in the middle of a group—that sort of thing. I may be after a while. So, there’s that sort of... I-I-I can remember as quite a young child backing out of things. Let’s say that my childhood was not guaranteed to bring up a mentally balanced child or adult, and leave it at that. You know, so umm—and, of course ha-having a bit of—because I used to wear leg irons. You know, you couldn’t run around with the other children—you could and I was stammering. I was wearing glasses in the days when “boys don’t make passes at girls in glasses”, all these sorts of things. So, it was—I was not—let’s say I learnt I was... safer in—on my own. And that has extended through my whole life because, at one stage I-I have had to live in a refuge. So, that sort of safer thing—it’s part of my...part of my make-up.

Eleanor, therefore, has experienced an accumulation of barriers—social, personal, and physical—and she attributed these barriers as spanning across her whole lifetime, making it difficult to find the right group that aligns with her needs for mental health support, an open/wide space, where she can physically participate, and access the venue. She also stressed that there is a lack of understanding of mental illness from group organizers and other participants, including in the setup of rooms (e.g. having options for leaving early).

However, she saw potential for getting into volunteering to look after cats:

So, like I almost need to... have my social life through doing something good, even if it’s only petting a few cats.

I: Yeah, yeah, I see what you mean. What um—yeah, can you tell me a bit more about why it is you feel that need? Why do you feel like you need to do that? Or what does it give you?

Eleanor: It gives me a reason to remain on Earth. It’s as fundamentally as that... It’s getting a bit difficult to talk about. Umm, I suppose it links into the depression. When you’re brought up to believe that you’d have no right to be yourself, and you have no value...as yourself, then, then the only value you can find is doing things for other people.

It is notable that what she describes here is a strong need to provide social value for, but not with people, nor does she ever mention receiving anything from other people. In contrast to Emma, who feels like a perpetual outsider looking for somewhere to belong, for Eleanor her lifelong experiences of solitude led her to search for ways to be socially useful or find some purpose.

‘I’m singing away and feeling terribly miserable’: The challenges of fitting in with others in groups

A third set of concerns were evident from participants who wanted to join groups but had some difficulty in making connections and getting along well with people. Participants
reasoned that they were too quiet, anxious, private, or low in self-esteem; others stated a
dislike of gossip and conflict; another challenge that was raised is the way topics of illness
or bereavement can disrupt conversations. We will illustrate two examples – one from a
person who found she does not get along well with people in groups, but wanted events
to look forward to, and the other is a person who wanted to be in groups but has difficulty
initiating conversations and making friends.

Elsie (Female in her 60s, retired, has spinal stenosis/ arthritis) used to spend a lot of her
time walking her dogs in a nature reserve, a place where ‘her kind of people’ could chat
and move on. It is where she formed all of her current friendships, but she can no longer
walk there:

I was very much an outdoor person and we’ve got a beautiful nature reserve and that at the
back – and, I very much love nature. And, not this one [refers to dog next to her], she’s a rescue
dog, but the other dogs, you’d spend hours up there – knew every inch of it you know – all the
animals – everything. And, uh, walking – going down by the river with the animals – and you
know, and talk to the people down there – and then you move on and – but now, because I’ve
got spinal stenosis and arthritis – I can barely walk, let alone – so, it’s a case now of trying to…find something that interests me without having to mix with a lot of people, if you see
what I mean?

What particularly appealed to Elsie in the nature reserve was that she did not have to
spend long talking to people she did not get along with; she could be selective and could
escape when she wanted to, and this environment is something she has struggled to
replicate elsewhere. She described groups and parties as tense and unnatural for her, as
she did not feel that she fits in:

I’m one of these that holds – I’ll sit back, or [coughs]… I sit back and tend to work people up.
Knowing… know – and, I find it difficult to trust people until I get to know them. So, - and
then, I’ve been called a snob, cos I don’t speak very much. But, I can go around like – if I went
to a barbecue where I knew everybody in the garden, I still don’t stop long. If I have to go –
and, I could know everybody, and I just don’t enjoy it. And, too many people, they all seem like
doing their own thing and you sit there, and you feel as if you should be acting silly or getting a
drink, or… you should – I always feel as if I should be trying to fit in, which makes me more
anxious to go- so, I can be myself again.

There were multiple reasons for Elsie’s dislike of social groups – including difficulty
trusting people (due to history of abuse), discomfort with people getting too personal, a
lack of common interest, and no desire to drink or gossip. Most importantly, she viewed
being around people as in conflict with ‘being myself’, and somewhat unusually perhaps,
this is no better when she knows everyone.

Conversely, Clara (Female, 60, widow) had been actively trying to seek out groups to
join; however, she’s had difficulty finding the right fit and often does not return to groups
she has tried before. Her favourite pastime is singing and she used to go with her husband,
but after he died, she had not been able to find that sense of belonging again.

I used to find – my stupid husband died on me twenty years ago – I had a great social life,
because what we did was sing and belonged to five different groups. So, we were out almost
every night rehearsing – singing for this, that and the other! – small groups, big groups, it
didn’t matter. We were a unit and it was WONDERFUL!…So, I did I used to belong to things,
but that’s because I think when I had a man in my life and some s- support you know –
someone to encourage you and to go with makes such a difference. You see, since I’ve been on my own I’ve just found I don’t know how to do it anymore.

Unlike most of the participants interviewed, Clara has previously experienced the joy of belonging to a group. However, it hinged on her husband’s encouragement and with his death, she now felt unable to access this collective experience. She later described chronically repeated experiences of not belonging anywhere, a feeling exacerbated at group meetings, because she is unable to approach people. At the time of interview, she had recently tried a new singing group where the first time she attended she did not know anyone.

Well, the best way to describe it is a mass karaoke. You all sing together and the words come up on the screen. I went a few times and in fact I can’t go up and say “hello, I’m the whatever” – so, I’m singing away and feeling terribly miserable. But now I’ve met somebody who goes and I went with them last Monday, and it was totally different. So, I’m hoping to be able to do that again. It makes it so much easier if I’ve got someone with me, I can’t tell you.

Thus, for Clara the key to being comfortable in groups rests on having a prior connection. She attributed this effect largely as being her own fault; despite her enjoyment of singing groups in the past, she never made lasting friendships that might have allowed her to continue, which she attributed to low self-esteem and an inability to take the first step in conversations.

Discussion
This study builds on how a social cure approach – with an emphasis on group belonging as a route to reducing loneliness and improving health and well-being (Haslam, McMahon, et al., 2018; Jetten et al., 2012) – can be harnessed in interventions, such as Social Prescribing (Stevenson et al., 2019). We interviewed a subsection of isolated or lonely middle to older aged people who said they did not like to join groups and identified themes regarding barriers to joining and integrating into groups.

Recognizing and addressing the challenges of being in groups
Some interviewees desired an improvement in their social connections and group memberships, but reported a multitude of barriers in their way. We noted how barriers may accumulate – examples include social interaction anxiety, health problems, venue accessibility issues, bereavement and negative early life social experiences. Groups that are large and unstructured or in enclosed spaces were particularly unpopular. What is striking is that people can get their hopes up – join a group – but be confronted with greater feelings of alienation or loneliness (see also Kellezi, Wakefield, et al., 2019). In turn, trying different groups seems needlessly stressful and people may then develop an idea that ‘groups are not for me’.

A particular finding is that participants often reported difficulty ‘being themselves’ while fitting in with others in a group. The social cure approach to health (Haslam, McMahon, et al., 2018; Jetten et al., 2012; Kellezi, Wakefield, et al., 2019) posits that people find belonging in groups where they are able to express positive, shared identities. In other words, they need to have the ability to be themselves and feel good about who they are, when in a group. However, encouraging an individual to join a group because
they have one identity that fits (e.g. a medical condition, or a shared interest) can potentially create tension or distress if other identities (or personality traits or preferences) come into conflict (see Haslam, Cruwys, Haslam, Dingle, & Chang, 2016, for techniques for dealing with identity incompatibility and discontinuity).

Due to these fraught experiences in groups, some participants felt that the public health messaging about joining groups was not enough to enable them to put words into action. This finding evidences the need for ongoing support in ‘scaffolding’ social connections and empowering people, as provided by link/social workers and volunteers who can attend sessions alongside people or help them to find more suitable alternative activities (Haslam et al., 2019; Kellezi, Wakefield, et al., 2019; Kimberlee, 2013).

In addition, this study highlights that people have different loneliness-related needs and anxieties about groups that need to be addressed in order for them to develop a shared identity with other group members (see Cruwys et al., 2020; Lim et al., 2016; Tarrant et al., 2016). Some participants believed groups exist so as to make friends and that their inability to make friends prevented the feeling of belonging (akin to relational connectedness, Hawkley, Browne, & Cacioppo, 2005); other participants described themselves as ‘caged tigers’ who find joining groups and interacting with others in crowded rooms exacerbate alienation or anxiety. For the latter people, they may have a different set of needs – such as the need for purpose and may prefer to contribute to an instrumental/task-focussed group (see Allport, (1957/1979); Tziner, 1982), or may seek only brief social interactions and the ability to leave social situations more readily. Being recognized and valued as a useful group member may be more important to some people (see Hawkley et al., 2005; Tajfel, 1981, on group-based recognition and cohesion).

Further, other participants were even more sceptical about the role of groups in their health care, either because they want an increased availability of formal services, or prefer to manage independently. These participants rejected the idea that they possess the ability or capacity to give back to others or that they should be part of anyone else’s solution. While being alone all of the time is associated with poorer health and well-being (Larson, 1997), it may be better than an uncomfortable or unwelcoming social environment. Voluntary solitude is associated with well-being (Nguyen, Ryan, & Deci, 2017). The key point is that participants expressed the desire to be listened to and supported in their wishes (see also Kellezi, Wakefield, et al., 2019).

**Strengths, limitations, and implications**

This study had an opportunistic sample, in a homogenously populated city, although we did recruit people from a range of public locations. Given our public recruitment strategy, it is also possible that we did not reach the most severely isolated or housebound part of the population, and this may be indicated in the results whereby participants did express some desire to join groups or events. We suggest that future research should expand efforts to understand systematic factors affecting people’s ability or inclination to join groups, and evaluate different group formats – particularly making efforts to survey people who decline or leave groups, or who do not leave their homes.

An important implication arising from this study is that many participants were aware of the public health messaging about joining groups as a means of improving their health and well-being; however, awareness was not sufficient for overcoming the barriers that make finding and integrating into the right group(s) possible. We suggest that an advantage of approaches such as Social Prescribing is in empowering individuals to overcome barriers to joining groups, and by matching them with groups where they are
more likely to fit. Fit may be based on a combination of personal circumstances, previous experiences, and their interests and psychological needs. Further, group offerings can be made more accommodating and diverse, including empathetic facilitation practices, structured introductions, space to move freely or leave early, options for different levels of participation (e.g. non-speaking options), accommodations for all types of disabilities, and giving group members’ ownership and freedom to make decisions (see Tarrant et al., 2016). Alternative types of activities or memberships may sometimes be more appropriate than group programmes. For example, belonging to a nature reserve/trust (see MacKerron & Mourato, 2013), solo volunteering (Harding, 2019; Narushima, 2005), or online groups (Leist, 2013) could still provide a sense of positive identification and belonging, without necessitating close social contact.

This study provides insights into how joining a group could have a detrimental health or well-being effect if it is the wrong fit for an individual; thus, care needs to be taken about the potential opportunities and risks of any social interventions. In particular, we suggest that messaging about joining groups needs to emphasize that people find avenues for expressing their identities, finding where they belong, and being validated or feeling valued, and that this may or may not entail a face-to-face group setting.

**Acknowledgements**

This work was supported by the Engineering and Physical Sciences Research Council grant ‘Socio-Technical Resilience for Targeted Community Healthcare’ (EP/P01013X/1), and the Devon County Council in partnership with Age UK Exeter. The funders had no role in the study. Thanks to Chloe Burrow from Age UK Exeter for participant recruitment and to Caroline Aird and Lisa Shrimpton for coordinating the research partnership with Age UK Exeter and University of Exeter. Thanks also to the participants for their invaluable perspectives.

**Conflicts of interest**

All authors declare no conflict of interest.

**Data availability statement**

Anonymised transcripts are privately stored on figshare (https://figshare.com/articles/dataset/__/12613025) and can be requested from the corresponding author.

**References**

Allport, G. W. (1957/1979). *The nature of prejudice*. Cambridge, MA: Perseus Books.

BBC (2019). *Take part in the BBC Loneliness Experiment. All in the mind*. https://www.bbc.co.uk/programmes/articles/3MQ6z2vJGGpFL71Ns3XPNB/take-part-in-the-bbc-loneliness-experiment

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*, 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Campaign to End Loneliness (2019). https://www.campaigntoendloneliness.org/the-facts-on-loneliness/
Cruwys, T., Steffens, N. K., Haslam, S. A., Haslam, C., Hornsey, M. J., McGarty, C., & Skorich, D. P. (2020). Predictors of social identification in group therapy. *Psychotherapy Research, 30*, 348–361. https://doi.org/10.1080/10503307.2019.1587193

Cruwys, T., Wakefield, J. R. H., Sani, F., Dingle, G. A., & Jetten, J. (2018). Social isolation predicts frequent attendance in primary care. *Annals of Behavioral Medicine, 52*, 817–829. https://doi.org/10.1093/abm/kax054

Dare, J., Wilkinson, C., Donovan, R., Lo, J., McDermott, M.-L., O’Sullivan, H., & Marquis, R. (2019). Guidance for research on social isolation, loneliness, and participation among older people: Lessons from a mixed methods study. *International Journal of Qualitative Methods, 18*, 160940691987291. https://doi.org/10.1177/1609406919872914

DeMarco, T. C., & Newheiser, A.-K. (2019). When groups do not cure: Group esteem moderates the social cure effect. *European Journal of Social Psychology, 49*, 1421–1438. https://doi.org/10.1002/ejsp.2594

Duncan, D., & Bell, R. (2015). *Local action on health inequalities: Reducing social isolation across the lifecourse*—practice resource. Public Health England. http://www.instituteofhealthequity.org/resources-reports/local-action-on-health-inequalities-reducing-social-isolation-across-the-lifecourse/local-action-on-health-inequalities-reducing-social-isolation-across-the-lifecourse-full.pdf

Ellard-Gray, A., Jeffrey, N. K., Choubak, M., & Crann, S. E. (2015). Finding the hidden participant: Solutions for recruiting hidden, hard-to-reach, and vulnerable populations. *International Journal of Qualitative Methods, 14*(5), 160940691562142. https://doi.org/10.1177/1609406915621420

Glei, D. A., Landau, D. A., Goldman, N., Chuang, Y.-L., Rodríguez, G., & Weinstein, M. (2005). Participating in social activities helps preserve cognitive function: An analysis of a longitudinal, population-based study of the elderly. *International Journal of Epidemiology, 34*, 864–871. https://doi.org/10.1093/ije/dyi049

GOV.UK. (2018). *Government’s work on tackling loneliness*. https://www.gov.uk/government/collections/governments-work-on-tackling-loneliness

Greenaway, K. H., Cruwys, T., Haslam, S. A., & Jetten, J. (2016). Social identities promote well-being because they satisfy global psychological needs. *European Journal of Social Psychology, 46*, 294–307. https://doi.org/10.1002/ejsp.2169

Harding, K. (2019). *The rabbit effect: Live longer, happier, and healthier with the groundbreaking science of kindness*. Atria Books.

Haslam, C., Cruwys, T., Haslam, S. A., Dingle, G., & Chang, M.-X.-L. (2016). Groups 4 Health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health. *Journal of Affective Disorders, 194*, 188–195. https://doi.org/10.1016/j.jad.2016.01.010

Haslam, C., Haslam, S. A., & Cruwys, T. (2019). Social scaffolding: Supporting the development of positive social identities and agency in communities. In R. Williams, V. Kemp, S. A. Haslam, C. Haslam, K. S. Bhui & S. Bailey (Eds.), *Social scaffolding: Applying the lessons of contemporary social science to health and healthcare* (pp. (pp. 244.).). Cambridge, UK: Cambridge University Press.

Haslam, C., Jetten, J., Cruwys, T., Dingle, G., & Haslam, S. A. (2018). *The new psychology of health. Unlocking the social cure*. London: Routledge.

Haslam, S. A., McMahon, C., Cruwys, T., Haslam, C., Jetten, J., & Steffens, N. K. (2018). Social cure, what social cure? The propensity to underestimate the importance of social factors for health. *Social Science & Medicine, 198*, 14–21. https://doi.org/10.1016/j.socscimed.2017.12.020

Haslam, S. A., Reicher, S. D., & Levine, M. (2012). When other people are heaven, when other people are hell: How social identity determines the nature and impact of social support. In J. Jetten, C. Haslam & S. A. Haslam (Eds.), *The social cure: Identity, health and well-being* (pp. 157–174). London, NY: Psychology Press.

Häusser, J. A., Junker, N. M., & van Dick, R. (2020). The how and the when of the social cure: A conceptual model of group- and individual-level mechanisms linking social identity to health and
Hawkley, L. C., Browne, M. W., & Cacioppo, J. T. (2005). How can I connect with thee? Let me count the ways. *Psychological Science, 16*, 798–804. https://doi.org/10.1111/j.1467-9280.2005.01617.x

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine, 7*, e1000316. https://doi.org/10.1371/journal.pmed.1000316

Iyer, A., Jetten, J., Tsivrikos, D., Postmes, T., & Haslam, S. A. (2009). The more (and the more compatible) the merrier: Multiple group memberships and identity compatibility as predictors of adjustment after life transitions. *British Journal of Social Psychology, 48*, 707–733. https://doi.org/10.1348/014466608X397628

Jetten, J., Branscombe, N. R., Haslam, S. A., Haslam, C., Cruwys, T., Jones, J. M., … Zhang, A. (2015). Having a lot of a good thing: Multiple important group memberships as a source of self-esteem. *PLoS One, 10*, e0124609. https://doi.org/10.1371/journal.pone.0124609

Jetten, J., Haslam, C., & Haslam, S. A. (Eds.) (2012). *The social cure: Identity, health and well-being*. London, NY: Psychology Press.

Jetten, J., Haslam, S. A., Iyer, A., & Haslam, C. (2009). Turning to others in times of change: Social identity and coping with stress. In S. Sturmer & M. Snyder (Eds.), *The psychology of prosocial behavior: Group processes, integrative relations, and helping*. West Sussex, UK: John Wiley & Sons.

Jo Cox Foundation (2016). *The Jo Cox loneliness commission*. https://www.jocoxfoundation.org/loneliness_commission

Kellezi, B., Bowe, M., Wakefield, J. R., McNamara, N., & Bosworth, M. (2019). Understanding and coping with immigration detention: Social identity as cure and curse. *European Journal of Social Psychology, 49*, 333–351. https://doi.org/10.1002/ejsp.2545

Kellezi, B., Wakefield, J. R. H., Stevenson, C., McNamara, N., Mair, E., Bowe, M., … Halder, M. M. (2019). The social cure of social prescribing: A mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. *British Medical Journal Open, 9*, e033137. https://doi.org/10.1136/bmjopen-2019-033137

Kimberlee, R. (2013). *Developing a social prescribing approach for Bristol*. Bristol CCG. https://www.bristol.gov.uk/committee/2013/ot/ot049/1128_7.pdf

Larson, R. W. (1997). The emergence of solitude as a constructive domain of experience in early adolescence. *Child Development, 68*(1), 80–93. https://doi.org/10.2307/1131927

Leist, A. K. (2013). Social media use of older adults: A mini-review. *Gerontology, 59*, 378–384. https://doi.org/10.1159/000346818

Lim, M. H., Rodebaugh, T. L., Zyphur, M. J., & Gleeson, J. F. (2016). Loneliness over time: The crucial role of social anxiety. *Journal of Abnormal Psychology, 125*(5), 620. https://doi.org/10.1037/abn0000162

MacKerron, G., & Mourato, S. (2013). Happiness is greater in natural environments. *Global Environmental Change, 23*, 992–1000. https://doi.org/10.1016/j.gloenvcha.2013.03.010

Matschke, C., & Fehr, J. (2015). Internal motivation buffers the negative effect of identity incompatibility on newcomers’ social identification and well-being. *Social Psychology, 46*, 335–344. https://doi.org/10.1027/1864-9355/a000250

Narushima, M. (2005). 'Payback time': Community volunteering among older adults as a transformative mechanism. *Ageing and Society, 25*, 567–584. https://doi.org/10.1017/S0144686X05003661

Nguyen, T.-V.-T., Ryan, R. M., & Deci, E. L. (2017). Solitude as an approach to affective self-regulation. *Personality and Social Psychology Bulletin, 44*(1), 92–106. https://doi.org/10.1177/0146167217735073

Normansell, R., Holmes, R., Victor, C., Cook, D. G., Kelly, S., Iliffe, S., … Harris, T. (2016). Exploring non-participation in primary care physical activity interventions: PACE-UP trial interview findings. *Trials, 17*(1), 178. https://doi.org/10.1186/s13063-016-1299-z
Rook, K. S. (1984). Research on social support, loneliness, and social isolation: Toward an integration. *Review of Personality & Social Psychology, 5*, 239–264. https://psycnet.apa.org/record/1986-17262-001

Steffens, N. K., Cruwys, T., Haslam, C., Jetten, J., & Haslam, S. A. (2016). Social group memberships in retirement are associated with reduced risk of premature death: Evidence from a longitudinal cohort study. *British Medical Journal Open, 6*, e010164. https://doi.org/10.1136/bmjopen-2015-010164

Steffens, N. K., Jetten, J., Haslam, C., Cruwys, T., & Haslam, S. A. (2016). Multiple social identities enhance health post-retirement because they are a basis for giving social support. *Frontiers in Psychology, 7*, 1519. https://doi.org/10.3389/fpsyg.2016.01519

Stevenson, C., Wilson, I., McNamara, N., Wakefield, J. R. H., Kellezi, B., & Bowe, M. (2019). Social prescribing: A practice in need of a theory. *British Journal of General Practice, 69*(678), 6–7.

Tajfel, H. (1981). *Human groups and social categories: Studies in social psychology*. Cambridge, UK: Cambridge University Press/CUP Archive.

Tarrant, M., Warmoth, K., Code, C., Dean, S., Goodwin, V. A., Stein, K., & Sugavanam, T. (2016). Creating psychological connections between intervention recipients: development and focus group evaluation of a group singing session for people with aphasia. *British Medical Journal Open, 6*(2), e009652. https://doi.org/10.1136/bmjopen-2015-009652

Tziner, A. (1982). Group cohesiveness: A dynamic perspective. *Social Behavior and Personality: An International Journal, 10*, 205–211. https://doi.org/10.2224/sbp.1982.10.2.205

Wakefield, J. R. H., Bowe, M., Kellezi, B., McNamara, N., & Stevenson, C. (2019). When groups help and when groups harm: Origins, developments, and future directions of the “Social Cure” perspective of group dynamics. *Social and Personality Psychology Compass, 13*(3), e12440. https://doi.org/10.1111/spc3.12440

Wentowski, G. J. (1981). Reciprocity and the coping strategies of older people: Cultural dimensions of network building. *The Gerontologist, 21*, 600–609. https://doi.org/10.1093/geront/21.6.600

Received 25 August 2020; revised version received 23 April 2021

**Supporting Information**

The following supporting information may be found in the online edition of the article:

**Appendix S1.** Interview schedule.