AWARENESS, COURAGE, AND LOVE (ACL) GROUPS: A GERIATRIC PSYCHIATRY INPATIENT PILOT INTERVENTION FOR LONELINESS

Loneliness intervention for geriatric psychiatry

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Research Protocol

Background and Rationale

Loneliness is a key predictor of mortality in older adults. It is also a prominent risk factor for mental and physical illness in older adulthood (Ong et al., 2016). Concurrently, the population of older adults is rising to unprecedented levels. Group-based interventions that target loneliness in geriatric psychiatry patients would be an efficient use of limited resources to address this common psychosocial need. In their meta-analysis, Masi et al. (2011, p. 23) recommended a "rich and forgiving social environment" for lonely individuals to correct their maladaptive social cognitions. Several recommendations from meta-analyses on loneliness interventions have also stressed that more randomized group comparisons are needed (Cohen-Mansfield & Perach, 2015; Poscia et al., 2018). To our knowledge, no interventions for loneliness thus far have been trialed upon geriatric psychiatry inpatients.

Inpatient psychiatry units are ideally suited for piloting a novel intervention for loneliness that is based on Awareness, Courage, and Love (ACL) groups. Awareness, Courage, and Love (ACL) groups are an outgrowth of functional analytic psychotherapy, which is an empirically-based behavioural therapy that emphasizes the principle of positive reinforcement within relationships (Holman et al., 2017; Kanter et al., 2010; Kohlenberg & Tsai, 1991; Tsai et al., 2009a). Awareness involves the practice of mindfulness, and in particular, the noticing of emotions within oneself and in others (Tsai et al., 2009b). Courage refers to engaging in vulnerable self-disclosures. Love encompasses healthy caring for oneself and others, and in particular, responding affirmingly to another person's self-disclosures. ACL groups are led by skilled facilitators across the globe to address loneliness in the community (https://www.livewithacl.org/). Outcomes of these groups have included increased feelings of closeness with others (Tsai et al., 2020), social connectedness (Kanter et al., 2018), relational health (Hardebeck, 2022), and mindfulness (Kohlenberg et al., 2015). Elsewhere Maitland et al. (2017) have theorized about the processes within the ACL model that improve social functioning.

Bringing ACL groups to geriatric psychiatry inpatients represents a promising avenue towards better health outcomes. In Akhter-Khan and Au's (2020) literature review of *Why Loneliness Interventions Are Unsuccessful*, they underscored the dearth of loneliness interventions that are theory-based and called for ideas. Theoretically rooted in functional contextualism, and bolstered by empirical support in community samples, ACL groups adapted for geriatric psychiatry inpatients may answer that call. These groups would be a novel offering with potential for global impact.

Note. Elaboration on the Awareness Exercises: As noted in the protocol, the "self" component of awareness refers to paying attention to one's inner experiences. Awareness is one aspect of mindfulness known more formally as *present moment awareness*. Each awareness exercise in the protocol has been outlined: Session 1's awareness exercise is the Treasure Chest Meditation (p. 7), Session's 2 awareness exercise is the poem by John O'Donohue (p. 9), Session 3's awareness exercise is the meditation on loss, and Session 4's awareness exercise is the Seeing Deeply into Another meditation (p. 12).

Objectives and Hypotheses:

The objective of this clinical trial is to adapt, implement, and evaluate an ACL group for older adults in a psychiatric unit. This trial will *not* target psychiatric disorders, but rather, addressing a common psychosocial need in a psychiatric sample: the need for social closeness and belonging. The following research questions will be answered: (a) Are ACL groups with geriatric psychiatry inpatients feasible and acceptable? (b) Do such ACL groups demonstrate preliminary efficacy?

Accordingly, it is hypothesized that such groups will be well-received by geriatric psychiatry inpatients, as indicated on post-treatment program satisfaction questionnaires. Feasibility will be determined by the difference or lack thereof in attrition rate of the ACL group compared to TAU. Additionally, it is hoped the loneliness group will alleviate loneliness and boost social connectedness compared to treatment-as-usual.

Methodology:

Participants will complete simple, abbreviated surveys either orally or independently using pencil-and-paper. The primary outcomes will be loneliness and social functioning. Measures will be selected based on their psychometric properties and use with older adult samples. Before the first session (baseline) and after the last session, measures for loneliness, social closeness, relational health, subjective wellbeing, and sacred moments will be completed. All measures, except those related to program satisfaction, will be administered a final time at follow-up.

To assess the efficacy of the ACL groups, the Inclusion of Other in the Self Scale, UCLA Loneliness Scale-6 (ULS-6), De Jong Gierveld Loneliness Scale (DGLS), and Relational Health Indices will be administered. The Inclusion of Other in the Self Scale (Aron et al., 1992) is a one-item, pictorial indicator of social closeness. The ULS-6 has been validated with older adults (Neto, 2014) and the DGLS (1985) captures social loneliness. Moreover, relational health will be measured with the peer version of the Relational Health Indices (Liang et al., 2002). In terms of secondary outcomes, subjective wellbeing will be assessed using a one-item pictorial life satisfaction indicator (Cantril, 1965). Sacred moments will be captured by the Sacred Moments Scale (Pargament et al., 2014).

To assess the acceptability of the ACL groups, program satisfaction surveys will be administered after the final session. Acceptability will be assessed qualitatively with the Satisfaction Questionnaire, which includes open-ended items about group experiences, including what was most helpful, least helpful, and perceived changes as a result of the group (Owen et al., 2014). A quantitative measure of program satisfaction will also be completed, with acceptability and satisfaction items adapted from Simmons et al. (2013). To assess the feasibility of the ACL groups, attrition rates between the ACL group and with the Mutual Help group will be compared. Session feedback forms will also be completed after every session in both groups. Tables 1 and 2 below depict the administration of measures for each condition at every time point.

Design:

The design will use an experimental treatment-outcome design with a treatment-as-usual (TAU) control group. Participants will be randomly assigned into the ACL or Mutual Help group for four weeks (i.e., four sessions, respectively). Mutual Help groups represent the standard of care. They have been offered weekly in the geriatric psychiatry unit, serving as a voluntary, semi-structured forum to discuss news related to the ward, practice gratitude, offer suggestions to

improve the inpatient experience. These groups are facilitated by social workers, occupational therapists, and therapeutic recreation specialists.

ACL groups were selected for the purpose of this study. They will be facilitated by the social workers and psychologist. To prevent participant crossover during the active research phase, the Mutual Help and ACL groups will be scheduled to occur at the same time. There will be a comparison between the preliminary efficacy of four weekly ACL groups versus four Mutual Help Meetings in the geriatric psychiatry unit. The duration of ACL treatment was set at four weeks to allow for a full course of therapy. Each ACL session will last approximately 60 minutes. Outcomes will be measured pre- and post- treatment, in addition to between-groups comparisons with the ACL and Mutual Help groups. Session-by-session measures will also be completed after each ACL and Mutual Help meeting. Additionally, patients will be contacted two weeks after their final session of ACL and Mutual Help to complete follow-up measures. Efficacy will be established by improvements in outcome measures at post-treatment and/or follow-up relative to baseline.

Note. Patients are not invited back to inpatients group if discharged.

Note. According to Yalom (1975), the convention for group psychotherapy census is 5-8 and we adhere to that range.

Participants

The sample will consist of geriatric psychiatry inpatients, given their elevated risk for loneliness and poorer mental health. Given the flow of admissions and in anticipation of dropout, the target recruitment number is 50 inpatients, with a minimum of 5 participants in each of the two groups who attend four sessions. Inclusion criteria include admission to the geriatric psychiatry inpatient unit and the capacity to consent to group psychotherapy. Exclusion criteria would be individuals who are disoriented to person, delirious, unable to tolerate or participate meaningfully in the group, or otherwise unable to provide consent research and psychotherapy. To maximize inclusivity, no limitations will be based on age, sex, gender, or disease. Of note, the aforementioned criteria pertain only to the individuals recruited for the study and who will be randomized into ACL or Mutual Help groups.

Participation in this study will have risks comparable to TAU. These risks are mitigated by the facilitators' backgrounds and training in inpatient geriatric mental health. Adverse impact of the ACL group on participants' health, such as the exacerbation of depressive, manic, or psychotic symptoms, as reported by participants and/or nursing staff would be grounds for withdrawal from the study. The study will be terminated in the event that the ACL group systematically induces paradoxical effects, such as an increase in social isolation or decrease in wellbeing.

Statistical/Analysis Considerations:

Demographics between treatment and control groups will be compared with the expectation of comparable findings in terms of age, gender, income, cognitive functioning, and primary mental health diagnoses. After verifying statistical assumptions, mixed ANOVAs will be conducted to determine if there is an interaction between time (3 levels: baseline, post-treatment, and follow-up) and group (2 levels: control, treatment) on each of the continuous outcome variables. If there is a significant interaction, simple main effects analyses will uncover nuances at each level between groups.

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Table 1. Treatment Group Measure Administration

Measure	T1 (Pre)	W1	W2	W3	W4 T2 (Post)	T3 (2 wk FU)
Demographics	X					
De Jong Gierveld Loneliness	X				X	X
UCLA Loneliness	X				X	X
Cantril Life Satisfaction	X				X	X
Adaptation of Inclusion of Other in Self Scale					X	
Relational Health Indices					X	
Sacred Moment Qualities					X	
Session Feedback Process Measure		X	X	X	X	
Program Satisfaction Questionnaire Qualitative					X	
Program Satisfaction Quantitative					X	

Table 2. Control Group Measure Administration

Measure	T1 (Pre)	W1	W2	W3	W4 T2 (Post)
Demographics	X				
De Jong Gierveld Loneliness	X				X
UCLA Loneliness	X				X
Cantril Life Satisfaction	X				X
Adaptation of Inclusion of Other in Self Scale					X
Relational Health Indices					X
Sacred Moment Qualities					X
Session Feedback Process Measure		X	X	X	X
Program Satisfaction Questionnaire Qualitative					X
Program Satisfaction Quantitative					X