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Public perceptions and experiences of social distancing and social isolation during the COVID-19 pandemic: A UK-based focus group study.

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3 **Public perceptions and experiences of social distancing and social isolation**
4 **during the COVID-19 pandemic: A UK-based focus group study.**
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ABSTRACT

OBJECTIVE: Explore the perceptions and experiences of the UK public of social distancing and social isolation measures related to the COVID-19 pandemic.

DESIGN: Qualitative study comprising five focus groups carried out online during the early stages of the UK's social distancing and isolation measures (5-12 days post lockdown).

SETTING: Online video-conferencing

PARTICIPANTS: 27 participants, all UK residents aged 18 years and older, representing a range of gender, ethnic, age and occupational backgrounds.

RESULTS: The social distancing and isolation associated with COVID-19 policy has had having substantial negative impacts on the mental health and wellbeing of the UK public within a short time of policy implementation. It has disproportionately negatively affected those in low-paid or precarious employment. Practical social and economic losses - the loss of (in-person) social interaction, loss of income and loss of structure and routine – led to psychological and emotional ‘losses’ – the loss of motivation, loss of meaning, and loss of self-worth. Participants reported high adherence to distancing and isolation guidelines but reported seeing or hearing of non-adherence in others. A central concern for participants was the uncertainty duration of the measures, and their ability to cope longer-term. Some participants felt they would have lingering concerns over social contact while others were eager to return to high levels of social activity.

CONCLUSIONS: A rapid response is necessary in terms of public health programming to mitigate the mental health impacts of COVID-19 social distancing and isolation. Initial high levels of support for, and adherence to, social distancing and isolation is likely to wane over time, particularly where end dates are uncertain. Social distancing and isolation ‘exit strategies’ must account for the fact that, although some individuals will voluntarily or

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3 habitually continue to socially distance, others will seek high levels of social engagement as
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5 soon as possible.
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10 **Strengths and limitations of this study**

- 15 • A strength of this study is that it can help to inform social distancing and
16 isolation ‘exit strategies’, since it provides evidence of how people are likely to
17 behave when these measures are removed or relaxed.
18
- 21 • Another strength of this study is that it is the first qualitative study of its kind to
22 provide evidence on the current mental health impacts of COVID-19 related social
23 distancing and isolation.
24
- 28 • Another strength is its finding of the various forms of ‘loss’ as a new concept
29 through which to understand the practical and emotional impacts of social
30 distancing and isolation on the public.
31
- 35 • A limitation of this study is that it does not include participants from vulnerable or
36 ‘high-risk’ groups (e.g. over-70s). Future research will seek to explore these
37 participants views on COVID-19 and social distancing.
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INTRODUCTION

The current coronavirus (COVID-19) pandemic presents the greatest threat to public health in living memory and promises to be the deadliest pandemic since 1918-19.[1-2] Pandemics are challenging for clinical and public health agencies and policymakers because of the scientific and medical uncertainty that accompanies novel viruses like COVID-19.[3-4] Since COVID-19 is a new virus, pharmaceutical interventions like vaccines are not presently available. Public health policy is therefore exclusively reliant on non-pharmaceutical interventions (NPIs). The key NPIs being used in relation to the COVID-19 pandemic in the UK and globally (in addition to personal hygiene advisories (e.g. emphasising regular and thorough handwashing)) are *social distancing* (e.g. prohibiting public gatherings, closing schools and other non-essential services, and keeping a distance of >2 metres apart from others) and *social isolation* (e.g. remaining indoors except for one brief outing for per day for physical activity or 'essential supplies').[5]

Due to the unprecedented scale and severity of the social distancing and social isolation measures being implemented in response to COVID-19, the social and psychological impacts on the public are also likely to be unprecedented in scale and severity. A recent rapid review of the psychological impact of quarantine found that longer quarantine duration, infection fears, frustration and boredom, inadequate supplies, inadequate information, financial loss and stigma were among the major stressors.[6] Another systematic review of the literature on NPIs in relation to pandemic influenza and SARS found that people actively evaluate NPIs in terms of criteria such as perceived necessity, efficacy, acceptability and feasibility.[7] Public views on social distancing and social isolation are ambivalent in some contexts because of their perceived adverse social and economic impacts and their ability to attract stigma, particularly amongst those required to self-isolate.[7] Existing research on social distancing and isolation highlights a number of

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3 challenges for public health policymakers, including a lack of trust in government;[8]
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5 concerns over strains in family resources;[8] gaps and confusions in some areas of pandemic
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7 information communication;[9] and low adherence to voluntary social isolation and relatively
8
9 low adherence to non-attendance at public gatherings.[10] Although there is existing research
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11 from past pandemics on its likely effects,[6] and new quantitative research is starting to
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13 emerge,[11] there is no published qualitative evidence on public perceptions and experiences
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15 of the psychological and social public experiences of COVID-19 related social distancing and
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17 social isolation, and its relation to adherence – a gap that the present study addresses.
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21 This study aimed to explore four main questions: (1) What are the social and
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23 psychological impacts of social distancing and isolation experienced by the UK public during
24
25 the COVID-19 pandemic? (2) What are people's views on government communication
26
27 around social distancing and isolation? (3) What are people's current experiences of
28
29 adherence in relation to social distancing and isolation? (4) What are people's views on the
30
31 future in regard to COVID-19 social distancing and isolation. This study therefore aims to
32
33 contribute to knowledge of adherence to social distancing and isolation policy to provide
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35 insight into how communication with the public on social distancing and isolation may be
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37 shaped and improved in the future.
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44 **PARTICIPANTS AND METHODS**

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46 Five online focus groups with 27 participants were run between March 28th and April 4th,
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48 2020 (5-12 days after lockdown commenced on the 23rd March 2020). Participants were
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50 adults aged 18 years or over currently residing in the UK. Under normal circumstances,
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52 online focus groups can be a useful way of eliciting public views related to matters of health
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54 and medicine, particularly from diverse and geographically dispersed participants [12-13] but
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56 were necessary due to social isolation policy.
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Purposive sampling was used to provide a diverse range of ages, genders, race/ethnicities and social backgrounds and to explore the study's research questions.[14-15] Potential participants were asked to complete a very brief demographic survey to provide background information and to facilitate recruitment of a diverse population (Table 1). Due to social distancing measures, it was necessary for all recruitment to be conducted online. Researchers used a combination of social media snowball sampling, online community and volunteer advertising sites and social media advertisements (Facebook ads).

Table 1: Demographic details reported by participants.

| Characteristic | N (%) |
|------------------------------------|---------|
| <i>Gender</i> | |
| Female | 13 (48) |
| Male | 14 (52) |
| <i>Age range</i> | |
| 18-24 | 7 (26) |
| 25-34 | 6 (22) |
| 35-44 | 8 (30) |
| 45+ | 6 (22) |
| <i>Ethnicity</i> | |
| White - British | 16 (59) |
| White – any other White background | 6 (22) |
| Asian or Asian British - Pakistani | 3 (11) |
| Mixed – White and Asian | 1 (4) |
| Other | 1 (4) |

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3 *Occupational Classification*
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|----------------------------------------------------|--------|
| 5 Managers, directors and senior officials | 2 (7) |
| 6 Professional occupations | 6 (22) |
| 7 Associate professional and technical occupations | 5 (19) |
| 8 Administrative and secretarial occupations | 1 (4) |
| 9 Skilled trades occupations | 1 (4) |
| 10 Caring, leisure and other service occupations | 1 (4) |
| 11 Sales and customer service occupations | 3 (11) |
| 12 Elementary occupations | 1 (4) |
| 13 Full-time student | 5 (19) |
| 14 Unclassified/occupation not provided | 2 (7) |

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28 *Note: occupational classifications coded using the Office for National Statistics (ONS) Occupation*
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31 *Coding Tool.*
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35 To ensure that online discussion was manageable, focus groups were kept to between 5-8
36 participants. Each group met virtually via a web video-conferencing platform (Zoom) for
37 between 60-90 minutes. Participants joined using both video and audio. All focus groups
38 were organised and moderated by SW (a medical social scientist). The topic guide for the
39 focus groups was initially developed using existing literature on public attitudes and
40 experiences in past pandemics and was tested and refined in a pilot focus group. The main
41 topics for the focus groups were: general views on social distancing and isolation; health
42 impacts of social distancing and isolation; views on government COVID-19 advice and
43 communication; and views on compliance with, and the future impacts of, social distancing
44 and isolation.
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Analysis

Data collection and analysis followed an iterative process, whereby emergent themes from early focus groups were used to add to or refine questions and prompts during subsequent focus groups. All focus groups were recorded and transcribed for coding. SW and KD analysed the transcripts and developed and applied the thematic coding framework. Themes were discussed and developed with CJA and TT during virtual research group meetings. To help analysis we looked to validate “sensitive moments” between groups that indicated difficult but important issues.[16] Negative case analysis was used to seek for information that did not fit emergent themes, and where this occurred, themes were modified accordingly.[17]. Following a grounded theory approach, data were organised into primary and more focused codes that provided insight into identified themes.[14,18] Data collection and analysis continued until saturation occurred (that is, until no new significant themes emerged).[18] Data were analysed in NVivo (version 11.4.3, QRS).

Patient and Public Involvement

No patients were involved in this study. The public were not involved in the development of the research question, research design or outcome measures. A pilot focus group with participants not included in the present paper was used to help test and refine the focus group questions. Summary results were disseminated via email to participants prior to publication for feedback and comment.

RESULTS

Analysis revealed four broad themes: (1) the negative social and psychological impacts of social distancing and isolation during the COVID-19; (2) criticisms of government communication around social distancing and isolation; (3) current adherence and non-

1
2
3 adherence of self and others; and (4) Uncertainty, social-reintegration and the future. Within
4 each broad theme were a number of substantive sub-themes that are discussed below,
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6 supplemented by indicative quotes in Boxes 1-4.
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10 11 12 **The social and psychological impacts of COVID-19 social distancing and isolation** 13

14 All participants felt that the social distancing and isolation policies had had significant social
15 and psychological impacts on their lives and the central theme was loss (Box 1). This
16 experience of loss, which one participant likened to a process of “grieving” (a male
17 participant in their 40’s), consisted of three practical social and economic losses: loss of (in-
18 person) social interaction, loss of income, and loss of structure and routine. These in turn led
19 to three psychological and emotional “losses”: loss of motivation, loss of meaning, and loss
20 of self-worth.
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31 First, participants spoke of a loss of social interaction. The suddenness and
32 extensiveness of the lack of face-to-face contact had, even after only one week of lockdown,
33 already “taken its toll on mental health” (a male participant in their 20’s), leaving participants
34 feeling “alienated” (a male participant in their 20’s). A number talked about feeling
35 depressed or anxious as a result of social distancing or isolation, an experience some likened
36 to “a prison” (a female participant in their 30’s). Second, a number of participants discussed
37 how a loss of income, either through permanent loss of a job, or through temporary loss (via
38 lost clients or customers or being furloughed), had left them feeling “quite depressed” (a
39 female participant in their 30’s). Third, participants expressed of a loss of structure and
40 routine. The inability to go to work, or for some the significant re-structuring of work
41 patterns, including balancing home working with home schooling, meant that participants felt
42 “overwhelmed” (a female participant in their 30’s).
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3 Participants discussed how impacts like losing their job or not being able to go to
4 work, and not being able to socialise with friends, meant they experienced a general loss of
5 meaning in life. One participant already felt in need of professional mental health support,
6 less than two weeks into isolation. Participants also spoke of a loss of motivation to perform
7 basic everyday tasks, such as personal hygiene and grooming or exercising. For some, this
8 lack of motivation had left them feeling “sluggish” (a male participant in their 20’s). Finally,
9 participants expressed feeling a loss of self-worth. These emotional and psychological losses
10 were particularly acute for those living in more urban, densely populated cities like London
11 or Birmingham. They were also especially evident amongst those in low-paid or precarious
12 occupations, who had either lost their job or income or were now relying on parental, familial
13 or state financial support as a result of the pandemic.
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31 **Box 1: The social and psychological impacts of COVID-19 social distancing and**
32 **isolation**

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37 *Loss of social interaction*

38 “I’ve been working at home for the past week and a bit and it’s taken its toll ... because you think
39 social contact is such an important part of everyday life and now it’s like you walk down the street
40 and people are almost too scared to walk too close. It’s so alien.” (a male participant in their 20’s)
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48 “It’s all over the news, it’s all over your phone, it’s all over the TV, it’s basically everywhere you
49 turn you are hearing about it. All of a sudden, we can’t do these things we used to do, like going to
50 the shops and restaurants, and we just have to stay in, and I think people feel claustrophobic in both
51 a physical and an emotional sense.” (a male participant in their 20’s)
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Loss of structure and routine

“I feel really lazy at home. I feel sluggish. I feel out of my routine. I feel much less active, both mentally and physically. You know, not taking the trip to work every day. My working from home schedule is neither here nor there. Mentally I am not as sharp, I feel like I am taking lots of naps in the day.” (a male participant in their 20’s)

“I’m literally planning day-to-day as things go along. ... I’m not used to having the kids every single day because they are usually at school. It’s difficult to work around them, I can’t do anything with them, because I can’t go out. I feel so scared and don’t want to risk it.” (a female participant in their 30’s)

Loss of meaning

“All this talk about social distancing and things is so depressing, terrible, I mean I have even been contemplating on contacting *The Samaritans* just to be able to try to get through all this.” (a male participant in their 30’s)

“Being locked in a room trying to find something meaningful to do during the day, and I think it’s had a severe impact ... I hope something changes within a few weeks, so I am able to go out and live a fulfilling life” (a male participant in their 30’s)

Loss of motivation

“Physically it has had a toll on people. All day you are stuck at home. You eat, you sleep, you work, its gonna have an effect on the body, there is no real drive or motivation.” (a male participant in their 20’s)

“We are feeling very down and demotivated, very low very depressed to some extent... it’s become more stressful to get by and function on a daily basis.” (a male participant in their 30’s)

Loss of self-worth

“Your self-worth goes down a bit, because you can’t socialise with people and make yourself feel good about yourself.” (a male participant in their 30’s)

“The company I work for has closed down and I have had to apply for welfare assistance ... and I’ve had to go and live with my parents now, and they have had to support me financially. ... it’s been difficult, the whole mental health, the ability to function and get by, and being constantly locked in.” (a male participant in their 30’s)

Criticisms of government communication around social distancing and isolation

Most participants felt that guidance on social distancing and isolation had been generally unclear, although some described how it had “become clearer” over the course of the pandemic (a male participant in their 20’s) (Box 2). Many participants exhibited a lack of trust either in government, who were seen to be “politicising” the pandemic (a male participant in their 50’s), or in the media, who they felt were providing confusing information or “mixed messages” (a male participant in their 30’s). Participants felt that despite being locked at home, the constant media and social media attention on COVID-19 made them feel “claustrophobic in both a physical and an emotional sense” (a male participant in their 20’s), and that “seeing others in a heightened state of anxiety makes it harder to suppress that in yourself” (a female participant in their 40’s).

Another common criticism was over the ambiguity of terms such as ‘essential’ and ‘emergency’ supplies and services. This ambiguity, participants argued, meant that advice was either hard to follow or implement, or that “loopholes” could be exploited (a female participant in their 20’s) (see section below on compliance, non-compliance and the future).

Box 2: Views on government communication around social distancing and isolation*Mixed or unclear messages*

“After reading several news publications and channels, there has been much campaign around social distancing, and with isolation you normally associate it when you have got the virus yourself, but I think over the past week there have been several mixed messages over social distancing.” (a male participant in their 30’s)

“I’m trying to pick my way through what is happening, a lot of politicians are politicising it [COVID-19] and when you read the internet, it is very difficult to know what is real, true or valid, even if you read a broad church of views, facts and figures, it is still very difficult to make sense of it all.” (a male participant in their 50’s)

Ambiguous definitions

“Now everyone has been told that they have to stay in their houses, and people are thinking well ‘this can be classed as essential, and this can be classed as essential, whereas although we have been told a list of things we can do, people are finding loopholes and finding ways to get round them” (a female participant in their 20’s)

“I have seen loads of people outside, and I wonder how people will enforce that [penalty fines for not social distancing], I’m wondering how can someone prove they are going for an ‘emergency reason’?” (a male participant in their 30’s)

Current adherence and non-adherence of self and others

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3 All participants reported being highly adherent to government instructions on social
4 distancing (Box 3). Participants described how, despite the perceived lack of clarity
5
6 discussed above, they had been social distancing and isolating as far as possible. Participants
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8 also displayed a high degree of social consciousness, with many acknowledging that despite
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10 not perceiving themselves as being at high risk, they were doing it to “save lives” and protect
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12 those most vulnerable to the disease.
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17 Despite reporting their own high degree of adherence, many participants suggested
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19 that they had seen instances of non-adherence in others. Observations of non-adherence were
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21 associated with three main factors. First, non-adherence was seen to be due to a lack of
22
23 social conscience. Participants were generally critical of what they perceived to be a
24
25 minority of “inconsiderate” (a female participant in their 40’s) or “arrogant” (a male
26
27 participant in their 20’s) individuals who were not observing instructions related, for
28
29 example, to public gatherings and not keeping a distance of >2 metres apart from others when
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31 out for daily walks or runs. Second, non-adherence was seen to be due to a lack of
32
33 understanding. For example, participants argued that people who were not observing social
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35 distancing lacked knowledge over how they could help spread the disease even if they
36
37 themselves were not exhibiting symptoms. Third, non-adherence was seen to be due to a lack
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39 of enforcement. Many participants were critical that police were choosing to enforce social
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41 distancing restrictions or were not able to (due for example to the ambiguity of terms such as
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43 “essential” as discussed in the previous section). Others discussed how, despite their best
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45 efforts, supermarkets appeared to struggle to implement social distancing.
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54 **Box 3: Current adherence and non-adherence of self and others**

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58 *High levels of support for, and adherence to social distancing and isolation*
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3 “Staying at home is actually helping to save lives” (a female participant in their 20’s)
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7 “We have been in lockdown for 14 days, and because of my ... grandmother [in her 80s] who has
8 health problems, it [going out] is just not worth it.” (a male participant in their 20’s)
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14 *Non-adherence due to lack of social conscience*
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16 “I’m worried that people are going to take advantage of the nice weather and ruin it for people ...
17 Its insane because they have shut the park, but you get some inconsiderate people like a group of
18 lads playing football or people taking over the paths.” (a female participant in their 40’s)
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23
24 “The canal path we walk along is not 2 metres wide, but you can just about get around it if you go
25 on the verge and they go on the verge, and most people do but not everybody does ... I don’t say
26 anything because ... with all the publicity that’s out, if you are still choosing to do that, then me
27 telling you not to do it is not going to make a difference, it’s frustrating” a female participant in
28 their 40’s)
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37 *Non-adherence due to lack of understanding*
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39 The vast majority of people are taking it seriously and suffering to a certain extent, but there is a
40 minority who don’t necessarily understand it applies to them also. I know of people who have
41 gone to parks or gone for a picnic, because they think ‘well we don’t know anyone who has any
42 symptoms, and we’ve not got anything, so we can go about it in the same way’.” (a female
43 participant in their 20’s)
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52 *Non-adherence due to lack of enforcement*
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54 “They say that you are not allowed to go out for non-emergency reasons, which I don’t think a lot
55 of people are observing. People are just going out whenever they want. Those guidelines are in
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3 place by Boris [Johnson; UK Prime Minister] but no-one is really enforcing that. You see police
4 on the street, but they are not really doing anything.” (a male participant in their 30’s)
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10 “The supermarket they are not implementing, what’s the point in having the two-metre thing
11 outside when you can’t do that inside. ... I went to the supermarket and people respect it outside,
12 but as soon as you go inside there is [sic] people, they don’t care, they just come right up to you
13 and try to reach over you.” (a female participant in their 40’s)
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22 **Uncertainty, social-reintegration and the future**

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24 According to participants, “the biggest problem we’ve got is we don’t know when it’s going
25 to end” and the sense of “powerlessness” this had fostered (a male participant in their 50’s).
26
27 Despite their high level of current adherence, participants acknowledged there was a limit as
28 to how long they and others could adhere, at least without experiencing more severe social
29 and psychological suffering. Some participants felt that they would rather be told a specific
30 time frame, even if it was far in the future. Others feared that whilst they and others could
31 “get through” this initial phase of lockdown, going “in and out” of periods of lockdown (a
32 scenario some knew was possible due to the potential for COVID-19 to re-emerge in a
33 second wave) meant that “people will really struggle mentally” (a female participant in their
34 20’s). Some felt as though they could only take things “day-by-day” because anticipating
35 social distancing and isolation over a period of time was “too overwhelming” (a male
36 participant in their 50’s).
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52 Looking to the future, participants were divided as to how they felt they, and others,
53 would act when social distancing and isolation measures were either relaxed or removed.
54 Some felt that they and others would “go back to living my life completely as normal” (a
55 male participant in their 30’s) as soon as possible. These participants spoke of “being
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3 desperate to go out and go to restaurants or travel a lot” (a male participant in their 20’s) and
4 generally not taking a graded approach to social reintegration. They argued that if they were
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6 “told its ok” to socially reintegrate, then this was enough for them to “not feel too anxious
7
8 about going out with friends in the future” (a male participant in their 30’s). Others felt that
9
10 it would take them a longer to return to pre-pandemic social behaviours, and for example felt
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12 that they would continue to have “anxiety around health” (A female participant in their 30’s),
13
14 would be “cautious” about a “transition period where I stay in a bit more” (a male participant
15
16 in their 30’s) and that people in general might remain “socially distant” from one another (a
17
18 female participant in their 30’s).
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24 Others argued that how they would act would likely depend on the circumstances
25
26 under which social distancing and isolation measures were being relaxed or removed.
27
28 Specifically, this was tied to their perception of whether COVID-19 still posed a risk to them
29
30 or to society in general. They argued that, if a vaccine was available, then they would be
31
32 happy to return to their pre-pandemic activity.
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Box 4: Uncertainty, social-reintegration and the future

The challenge of future uncertainty

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42 “I would rather they [the government] said tonight, ‘you’re gonna be stuck in your houses until
43
44 September, than say, we will review in three weeks, and then say, we will review in three week,
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46 and keep doing that, I’d rather they set a date way in advance in the future because then you can
47
48 get your head around it.” (a male participant in their 20’s)
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55 “I’ve heard on the grapevine and online sources that we are in this lockdown for a few weeks or so,
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57 and then after 12 weeks or so we kind of get released and because we are not all immune
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necessarily it all comes back in a wave and then we have this constant thing of being locked down and then coming out and going back in again, ... and so I think it will go downhill, that's when people will struggle mentally because they've had that taste of freedom, and you don't know how long it's all going to finish." (a female participant in their 20's)

Perceptions of future behaviour

"I'm literally thinking day-by-day, because if one was to consider three months of this, and we are only two weeks in, it's just too much, it's too overwhelming." (a male participant in their 50's)

"People are not going to stay like this for another 6 months. It's for a good reason I know, but it's like a prison, we know what people are suffering mentally and emotionally, we don't know what people are going through behind their door ... When all this comes to an end we don't know how life is going to be. Is everybody going to be socially distant? It's scary." (a female participant in their 30's)

Alternative accounts and positive perceptions resulting from social distancing and isolation

Although the findings discussed above represent the most common views exhibited by participants, negative case analysis did reveal some alternative accounts. For example, some participants argued that social distancing and isolation "hadn't been hard" (a male participant in their 20's). However, these participants were all university students, and acknowledged that part of the reason it hadn't been as difficult for them was there had been no loss of income and, less loss of routine for them.

1
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3 A small number of participants argued that they were able to draw positives from the
4 social distancing and isolation due to COVID-19. For example, some described how
5 household quarantine had meant they could have “more time with their children” (a male
6 participant in their 30’s) or had brought family units together (a male participant in their
7 50’s). However, those participants who explicitly discussed the positives to be drawn from
8 social distancing and isolation were all from higher socio-economic backgrounds, and tended
9 to live in more rural or less densely populated areas of the UK.
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22 **DISCUSSION**

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24 Our findings suggest that a large proportion of the UK public may be suffering from feelings
25 of depression, anxiety, and loss as a result of COVID-19 social distancing and isolation.
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28 Some already feel in need of professional mental health support. The social and
29 psychological impacts identified through this study centred around the various losses that
30 people are experiencing. Practical social and economic losses - the loss of (in-person) social
31 interaction, loss of income and loss of structure and routine – led to psychological and
32 emotional losses – the loss of motivation, loss of meaning, and loss of self-worth. Findings
33 also suggest that participants generally found information on social distancing to be
34 ambiguous. However, there were differing views as to whether the government was at fault
35 (insufficiently clear communication) or that the terms themselves are ambiguous and a small
36 minority of the UK public were taking advantage of the ambiguity. It was recognized that
37 this ambiguity may have been designed to permit greater social freedom than the more
38 extreme social distancing and isolation measures implemented in other countries.
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54 Additionally, there was universally high adherence to social distancing and isolation
55 guidelines reported across the study sample, yet most participants had observed or heard of
56 non-adherence in others. Participants were highly critical of such instances of non-
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1
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3 adherence, citing lack of social conscience, lack of understanding and lack of enforcement as
4 likely causes. Perhaps the greatest concern for participants was the uncertainty they faced
5 over the duration of the social distancing and isolation measures, as well as their ability to
6 cope longer-term. There was also uncertainty as to how they and others would act, with some
7 fearful of lingering inhibitions and anxiety over social contact and health, and others eager to
8 return to normal levels of social activity.
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19 **Relevance to existing literature**

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21 Our findings on COVID-19 social distancing and isolation support some of the findings from
22 existing systematic reviews on previous pandemics related to influenza and SARS.[6-7] For
23 instance, we found that frustration or anxiety over loss of social interaction or loss of income,
24 inadequate or ambiguous information, and fears over the duration of social distancing and
25 isolation measures were all major themes.[6-8] However, contrary to previous research
26 which suggests that adherence with pandemic NPIs is lower in instances where people have
27 low trust in government and where people perceive themselves at relatively low risk from the
28 disease,[7] our participants were highly adherent to social distancing and isolation measures,
29 despite many lacking trust in government and perceiving themselves at low risk. In fact,
30 stigma was more likely to be attributed to those who were failing to socially distance and
31 isolate. Of course, as noted above the scale and severity of the pandemic and subsequent
32 measures are unprecedented. As such, although there is existing research on its likely
33 effects,[6] and although quantitative research is starting to emerge,[11] there is to, our
34 knowledge, no published qualitative evidence on public perceptions and experiences of the
35 psychological and social public experiences of COVID-19 related social distancing and
36 isolation, and its relation to adherence – a gap this study addresses.
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Limitations

One limitation of this study is that it is not possible to rule out that the high degree of adherence and social conscience that participants expressed was not at least partly affected by social desirability bias, which can often be encountered in focus group studies.[19] However, conducting focus groups online has been found to reduce social desirability bias (although it is worth noting that this is more so where asynchronous or text-only communication is used, and not video-conferencing as in our study).[12,20]

Another limitation of this study is that it did not recruit participants who are deemed at particularly high risk from COVID-19-related complications, for example, individuals aged 70 and over and those living with certain chronic health conditions (no participants were aged over 60 years old).[21] Because these individuals are likely to have been significantly affected by social distancing and isolation policy (being required to self-isolate for 12 weeks), their views will be important. It is also worth noting that our recruitment material did encourage those at high risk to apply, though we received no applications from those over-70. This may be partly due to the fact that those over-70 are a hard-to-reach group online, because they are significantly less likely to use social media or be heavy internet users,[22] which, due to the lack of online social support and interaction, might mean they are at particularly high risk of some of the negative social and psychological impacts discussed in this paper. Future research will explore at-risk groups' experiences in depth. Future papers will also explore further the similarities and differences in views and experiences in the perceptions of experiences of participants living in different parts of the UK (e.g. London compared to less densely populated areas), a theme only briefly discussed here due to limitations of scope.

Implications for policy and practice

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3 This study suggests that the social distancing and isolation associated with COVID-19 policy
4
5 is having substantial negative impacts on the mental health and wellbeing of the UK public
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7 within a short time of policy implementation. The prevalence of COVID-19-related
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9 depression and anxiety, and the extent to which it will last beyond the removal or relaxation
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11 of social distancing and isolation policies remains to be seen. Our ongoing research will
12
13 explore these social and psychological impacts longitudinally. Policymakers and the public
14
15 health community must discuss measures to respond to the likely wave of mental ill-health
16
17 which is expected to follow, and which is tentatively suggested by our early qualitative
18
19 evidence. The theme of loss and addressing public concerns around physical and emotional
20
21 losses (e.g. meaning and self-worth), may inform current and future therapeutic interventions.
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23 Loss of meaning and self-worth may be due in part to loss of control, and increasing a sense
24
25 of control for the public should be considered in future policy, intervention, and
26
27 programming.[23] Additionally, findings suggest that a rapid response is necessary in terms
28
29 of public health programming to mitigate these mental health impacts. Waiting until
30
31 restrictions and isolation measures are relaxed or removed to provide support services could
32
33 potentially have devastating impacts. Government and the public health authorities should
34
35 look at ways of extending mental health outreach services, especially remotely.[24] Timely
36
37 attention is needed for those who are predisposed to depression and anxiety, those who may
38
39 be suicidal, and those experiencing significant social, economic and personal loss.
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47 Our study also suggests that although the COVID-19 pandemic has had significant
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49 ramifications for many UK residents from diverse backgrounds, it has disproportionately
50
51 negatively affected those in low-paid or precarious employment. Future research and policy
52
53 should therefore seek to develop measures that specifically seek to remediate the social,
54
55 economic and psychological harms related to COVID-19 as experienced by those from
56
57 disadvantaged backgrounds. Looking ahead to later stages in the current pandemic, or to the
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3 development of pandemic preparedness programmes for the future, a couple of lessons can be
4 distilled, which warrant urgent attention. Firstly, initial high levels of support for, and
5 adherence to, social distancing and isolation measures are likely to wane over time,
6 particularly where end dates are and remain uncertain. Secondly, in planning the ‘exit
7 strategy’ for the UK lockdown, and its possible impact on future resurgences of COVID-19
8 infection, policymakers and public health authorities need to account for the fact that,
9 although some individuals will voluntarily or habitually continue to socially distance (graded
10 social reintegration) others will seek immediately to re-integrate fully beyond what they are
11 permitted to.
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17 **DECLARATIONS**

18
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49 **Transparency declaration:** The lead author (the manuscript's guarantor) affirms that the
50 manuscript is an honest, accurate, and transparent account of the study being reported; that no
51 important aspects of the study have been omitted; and that any discrepancies from the study
52 as planned (and, if relevant, registered) have been explained.
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30 were explicitly guaranteed that the data would only be seen by members of the study team.
31
32 For any discussions about the data set please contact the corresponding author, Simon
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3 **Public perceptions and experiences of social distancing and social isolation**
4 **during the COVID-19 pandemic: A UK-based focus group study.**
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ABSTRACT

OBJECTIVE: To explore UK public perceptions and experiences of social distancing and social isolation related to the COVID-19 pandemic.

DESIGN: A qualitative study comprising five focus groups, carried out online during the early stages of the UK's stay at home order ('lockdown'), and analysed using a thematic approach.

SETTING: Focus groups took place via online video-conferencing

PARTICIPANTS: Participants (n=27) were all UK residents aged 18 years and older, representing a range of gender, ethnic, age and occupational backgrounds.

RESULTS: Qualitative analysis revealed four main themes: (1) Loss – participants' loss of (in-person) social interaction, loss of income and loss of structure and routine led to psychological and emotional 'losses' such as loss of motivation, loss of meaning, and loss of self-worth; (2) Criticisms of government communication – participants reported a lack of trust in government and a lack of clarity in the guidelines around social distancing and isolation; (3) Adherence – participants reported high self-adherence to social distancing guidelines but reported seeing or hearing of non-adherence in others; (4) Uncertainty around social-reintegration and the future - some participants felt they would have lingering concerns over social contact while others were eager to return to high levels of social activity.

Most participants, and particularly those in low-paid or precarious employment, reported feeling that the social distancing and isolation associated with COVID-19 policy has had negative impacts on their mental health and wellbeing during the early stages of the UK's 'lockdown'.

CONCLUSIONS: A rapid response is necessary in terms of public health programming to mitigate the mental health impacts of COVID-19 social distancing and isolation. Social

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3 distancing and isolation ‘exit strategies’ must account for the fact that, although some
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5 individuals will voluntarily or habitually continue to socially distance, others will seek high
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7 levels of social engagement as soon as possible.
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12 **Strengths and limitations of this study**

- 17 • A strength of this study is that it can help to inform social distancing and
18 isolation ‘exit strategies’, since it provides evidence of how people are likely to
19 behave when these measures are removed or relaxed.
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- 22 • Another strength of this study is that it is the first qualitative study of its kind to
23 provide evidence on the current mental health impacts of COVID-19 related social
24 distancing and isolation.
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- 27 • Another strength is its finding of the various forms of ‘loss’ as a new concept
28 through which to understand the practical and emotional impacts of social
29 distancing and isolation on the public.
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- 32 • A limitation of this study is that it does not include participants from vulnerable or
33 ‘high-risk’ groups (e.g. over-70s).
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INTRODUCTION

The current coronavirus (COVID-19) pandemic presents a considerable challenge to public health in the UK and globally.[1-2] Pandemics are problematic for clinical and public health agencies and policymakers because of the scientific and medical uncertainty that accompanies novel viruses like COVID-19.[3] Since COVID-19 is a new virus, pharmaceutical interventions like vaccines are not presently available. Public health policy is therefore exclusively reliant on non-pharmaceutical interventions (NPIs). The key NPIs being used in relation to the COVID-19 pandemic in the UK and globally (in addition to personal hygiene advisories (e.g. emphasising regular and thorough handwashing) are *social distancing* and *social isolation*. Social distancing in the UK has included the banning of public gatherings, closure of schools and all non-essential shops, workplaces and services, and the recommendation of keeping a distance of >2 metres apart from others.[4] Social isolation guidelines in the UK have included a period of 7 days quarantine for those showing symptoms of, or testing positive for, COVID-19, and a 14 day quarantine period for others in the same household (although specific guidelines have varied over time).[4]

Due to the extent of the social distancing and social isolation measures being implemented in response to COVID-19, social and psychological impacts on the public are anticipated and warrant further attention.[5]. A recent rapid review of the psychological impact of quarantine found that longer quarantine duration, infection fears, frustration and boredom, inadequate supplies, inadequate information, financial loss and stigma were among the major stressors.[6] Another systematic review of the literature on NPIs in relation to pandemic influenza and SARS found that people actively evaluate NPIs in terms of criteria such as perceived necessity, efficacy, acceptability and feasibility.[7] Public views on social distancing and social isolation are ambivalent in some contexts because of their perceived

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2
3 adverse social and economic impacts and their ability to attract stigma, particularly amongst
4 those required to self-isolate.[7] Existing research on social distancing and isolation
5
6 highlights a number of challenges for public health policymakers, including a lack of trust in
7
8 government;[8] concerns over strains in family resources;[8] gaps and confusions in some
9
10 areas of pandemic information communication;[9] and low adherence to voluntary social
11
12 isolation and relatively low adherence to non-attendance at public gatherings.[10] Although
13
14 there is existing research from past pandemics on its likely effects,[6] and new quantitative
15
16 research is starting to emerge,[11] there is to our knowledge no published qualitative
17
18 evidence on public perceptions and experiences of the psychological and social impacts of
19
20 COVID-19-related social distancing and social isolation, and its relation to adherence. The
21
22 present study seeks to address this gap.
23
24
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26
27

28 This study explored four main questions: (1) What are the social and psychological
29
30 impacts of social distancing and isolation experienced by participants during the COVID-19
31
32 pandemic? (2) What are participants' views on government communication around social
33
34 distancing and isolation? (3) What are participants' current experiences of adherence in
35
36 relation to social distancing and isolation? (4) What are participants' views on the future in
37
38 regard to COVID-19 social distancing and isolation? This study therefore aims to contribute
39
40 to knowledge on adherence to social distancing and isolation policy to provide insight into
41
42 how communication with the public on social distancing and isolation may be shaped and
43
44 improved in the future.
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51 **PARTICIPANTS AND METHODS**

52 Five online focus groups with 27 participants were run between March 28th and April 4th,
53
54 2020. Data were collected 5-12 days after the UK government's 'stay at home'
55
56 announcement on the 23rd March 2020, where people were advised to leave their houses only:
57
58
59
60

1
2
3 to shop for basic necessities, take one form of exercise per day, for medical needs, or
4
5 travelling to work only when necessary and where home working was not possible.
6

7
8 Participants were all adults aged 18 years or over currently residing in the UK. Participants
9
10 were recruited from all four UK countries (England, Wales, Scotland and Northern Ireland).
11
12 Under normal circumstances, online focus groups can be a useful way of eliciting public
13
14 views related to matters of health and medicine, particularly from diverse and geographically
15
16 dispersed participants [12-13] but were necessary due to social isolation policy. Participants
17
18 gave both verbal and written informed consent. Ethical approval was received by Swansea
19
20 University's School of Management Research Ethics Committee.
21
22

23
24 Purposive sampling was used to provide a diverse range of ages, genders,
25
26 race/ethnicities and social backgrounds (Table 1).[14-15] Researchers used a combination of
27
28 social media snowball sampling, online community and volunteer advertising sites and social
29
30 media advertisements (Facebook ads). However, the final sample did consist of a large
31
32 proportion of white participants and participants aged under 45 years (see limitations section
33
34 for further discussion). Due to social distancing measures, it was necessary for all
35
36 recruitment to be conducted online.
37
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42 **Table 1: Demographic details reported by participants.**
43
44
45

| Characteristic | N (%) |
|------------------|---------|
| <i>Gender</i> | |
| Female | 13 (48) |
| Male | 14 (52) |
| <i>Age range</i> | |
| 18-24 | 7 (26) |
| 25-34 | 6 (22) |

| | |
|--------------------------------------------------|---------|
| 35-44 | 8 (30) |
| 45+ | 6 (22) |
| <i>Ethnicity</i> | |
| White - British | 16 (59) |
| White – any other White background | 6 (22) |
| Asian or Asian British - Pakistani | 3 (11) |
| Mixed – White and Asian | 1 (4) |
| Other | 1 (4) |
| <i>Occupational Classification</i> | |
| Managers, directors and senior officials | 2 (7) |
| Professional occupations | 6 (22) |
| Associate professional and technical occupations | 5 (19) |
| Administrative and secretarial occupations | 1 (4) |
| Skilled trades occupations | 1 (4) |
| Caring, leisure and other service occupations | 1 (4) |
| Sales and customer service occupations | 3 (11) |
| Elementary occupations | 1 (4) |
| Full-time student | 5 (19) |
| Unclassified/occupation not provided | 2 (7) |

Note: occupational classifications coded using the Office for National Statistics (ONS) Occupation Coding Tool.

To ensure that online discussion was manageable, focus groups were kept to between 5-8 participants. Each group met virtually via a web video-conferencing platform (Zoom) for between 60-90 minutes. Participants joined using both video and audio. All focus groups were organised and moderated by SW . The topic guide for the focus groups was initially

1
2
3 developed using existing literature on public attitudes and experiences in past pandemics and
4
5 was tested and refined in a pilot focus group. The main topics for the focus groups were:
6
7 general views on social distancing and isolation; health impacts of social distancing and
8
9 isolation; views on government COVID-19 advice and communication; and views on
10
11 compliance with, and the future impacts of, social distancing and isolation.
12
13
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15
16

17 **Analysis**

18
19 Data collection and analysis followed an iterative process, whereby emergent themes from
20
21 early focus groups were used to add to or refine questions during subsequent focus groups.
22
23 All focus groups were audio recorded and transcribed for coding. SW and KD analysed the
24
25 transcripts and developed and applied the thematic coding framework. Themes were
26
27 discussed and further developed with CJA and TT during virtual research group meetings.
28
29 To help analysis we looked to validate “sensitive moments” between groups that indicated
30
31 difficult but important issues.[16] Negative case analysis was used to seek for information
32
33 that did not fit emergent themes, and where this occurred, themes were modified
34
35 accordingly.[17] Analysis followed a thematic approach as described by Coffey and
36
37 Atkinson.[18] Here data analysis takes a pragmatic approach, whereby initial broad research
38
39 questions inform the abductive generation of themes.[18] Initial primary (open) codes was
40
41 developed, and were then developed and connected to other related themes to form
42
43 overarching secondary codes that were developed into the four themes described
44
45 below.[14,18] Data collection and analysis continued until saturation occurred (that is, until
46
47 no new significant themes emerged).[18] Data were analysed in NVivo (version 11.4.3,
48
49 QRS).
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58 **Patient and Public Involvement**

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60

1
2
3 No patients were involved in this study. The public were not involved in the development of
4 the research questions, research design or outcome measures. A pilot focus group with
5 participants not included in the present paper was used to help test and refine the focus group
6 questions. Summary results were disseminated via email to participants prior to publication
7 for feedback and comment.
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17 **RESULTS**

18
19 Analysis revealed four broad themes: (1) Loss (2) Lack of trust in, and clarity of, government
20 communication around social distancing and isolation (3) High levels of self-adherence but
21 observations of non-adherence in others; and (4) Uncertainty around social-reintegration and
22 the future. Within each broad theme were a number of substantive sub-themes that are
23 discussed below, supplemented by indicative quotes in Boxes 1-4.
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33 **Loss**

34
35 Many participants felt that the social distancing and isolation policies had had significant
36 social and psychological impacts on their lives, central to which was a feeling of loss. This
37 experience of loss, which one participant likened to a process of “grieving” (male participant
38 in their 40’s), consisted of three practical social and economic losses: loss of (in-person)
39 social interaction, loss of income, and loss of structure and routine. These in turn led to three
40 psychological and emotional “losses”: loss of motivation, loss of meaning, and loss of self-
41 worth.
42
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51 First, participants spoke of a loss of social interaction. The suddenness and
52 extensiveness of the lack of face-to-face contact had, even after only one week of lockdown,
53 already “taken its toll”, leaving participants feeling “alienated”:
54
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1
2
3 *I've been working at home for the past week and a bit and it's taken its toll ... because you*
4 *think social contact is such an important part of everyday life and now it's like you walk*
5 *down the street and people are almost too scared to walk too close. It's so alien. (male*
6
7
8
9 participant in their 20's)

10
11
12
13
14 A number talked about feeling depressed or anxious as a result of social distancing or
15
16 isolation, an experience some likened to “a prison” (a female participant in their 30's) or
17
18 feeling emotionally “claustrophobic”:
19

20
21
22
23 *It's all over the news, it's all over your phone, it's all over the TV, it's basically everywhere*
24 *you turn you are hearing about it. All of a sudden, we can't do these things we used to do, like*
25 *going to the shops and restaurants, and we just have to stay in, and I think people feel*
26
27
28
29 *claustrophobic in both a physical and an emotional sense. (male participant in their 20's)*
30

31
32
33
34 Second, a number of participants discussed how a loss of income, either through permanent
35
36 loss of a job, or through temporary loss (via lost clients or customers or being furloughed),
37
38 had left them feeling “quite depressed” (female participant in their 30's).
39

40
41 Third, participants expressed of a loss of structure and routine, which for some had
42
43 left them feeling “less active” or “sluggish”:
44

45
46
47 *I feel really lazy at home. I feel sluggish. I feel out of my routine. I feel much less active, both*
48 *mentally and physically. You know, not taking the trip to work every day. My working from*
49
50
51 *home schedule is neither here nor there. Mentally I am not as sharp, I feel like I am taking*
52
53
54 *lots of naps in the day. (male participant in their 20's)*
55
56
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1
2
3 The inability to go to work, or for some the significant re-structuring of work patterns,
4 including balancing home working with home schooling, combined with worry over the virus
5 itself, meant that many participants felt “overwhelmed” or “scared”:
6
7
8
9
10

11
12 *I'm literally planning day-to-day as things go along. ... I'm not used to having the kids every*
13 *single day because they are usually at school. It's difficult to work around them, I can't do*
14 *anything with them, because I can't go out. I feel so scared and don't want to risk it* (female
15 participant in their 30's)
16
17
18
19

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21
22
23 Participants discussed how impacts like losing their job or not being able to go to work, and
24 not being able to socialise with friends, meant they experienced a general loss of meaning in
25 life:
26
27
28
29
30

31
32 *Being locked in a room trying to find something meaningful to do during the day, and I think*
33 *it's had a severe impact ... I hope something changes within a few weeks, so I am able to go*
34 *out and live a fulfilling life* (male participant in their 30's)
35
36
37
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39

40
41 One participant already felt in need of professional mental health support, less than two
42 weeks into isolation:
43
44
45
46

47
48 *All this talk about social distancing and things is so depressing, terrible, I mean I have even*
49 *been contemplating on contacting The Samaritans just to be able to try to get through all this.*
50
51 (male participant in their 30's)
52
53
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1
2
3 Participants also spoke of a loss of motivation to perform basic everyday tasks, such as
4
5 personal hygiene and grooming or exercising, and how this demotivation was having an
6
7 effect on their physical health:
8
9

10
11
12 *Physically it has had a toll on people. All day you are stuck at home. You eat, you sleep, you*
13
14 *work, its gonna have an effect on the body, there is no real drive or motivation.”* (a male
15
16 participant in their 20’s)
17

18
19
20 For some, this lack of motivation had left them feeling “low” or “depressed”:
21
22

23
24
25 *We are feeling very down and demotivated, very low very depressed to some extent... it’s*
26
27 *become more stressful to get by and function on a daily basis.* (male participant in their 30’s)
28
29

30
31 Finally, participants suggested that an inability to socialise and the loss of social support led
32
33 to them feeling a loss of ‘self-worth’:
34
35

36
37
38 *Your self-worth goes down a bit, because you can’t socialise with people and make yourself*
39
40 *feel good about yourself.* (male participant in their 30’s)
41
42

43
44
45 These emotional and psychological losses were particularly acute for those living in more
46
47 urban, densely-populated cities like London or Birmingham. They were also especially
48
49 evident amongst those in low-paid or precarious occupations, who had either lost their job or
50
51 income or were now relying on parental, familial or state financial support as a result of the
52
53 pandemic:
54
55
56
57
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1
2
3 *The company I work for has closed down and I have had to apply for welfare assistance ...*
4
5 *and I've had to go and live with my parents now, and they have had to support me financially.*
6
7 *... it's been difficult, the whole mental health, the ability to function and get by, and being*
8
9 *constantly locked in.* (male participant in their 30's)
10
11
12
13

14 **Lack of trust in, and clarity of, government communication around social distancing** 15 **and isolation**

16
17
18 Most participants felt that guidance on social distancing and isolation had been generally
19
20 unclear, and that information about the pandemic had conveyed “mixed messages”:
21
22

23
24
25 *After reading several news publications and channels, there has been much campaign around*
26
27 *social distancing, and with isolation you normally associate it when you have got the virus*
28
29 *yourself, but I think over the past week there have been several mixed messages over social*
30
31 *distancing* (male participant in their 30's)
32
33
34
35

36 Many participants described a lack of trust either in government, who were seen to be
37
38 “politicising” the pandemic:
39
40
41

42
43 *I'm trying to pick my way through what is happening, a lot of politicians are politicising it*
44
45 *[COVID-19] and when you read the internet, it is very difficult to know what is real, true or*
46
47 *valid, even if you read a broad church of views, facts and figures, it is still very difficult to*
48
49 *make sense of it all.* (male participant in their 50's)
50
51
52

53 As noted in the previous section, some participants found that being locked at home coupled
54
55 with constant media and social media attention on COVID-19 made them feel
56
57 “claustrophobic in both a physical and an emotional sense” (male participant in their 20's),
58
59
60

1
2
3 and that “seeing others in a heightened state of anxiety makes it harder to suppress that in
4
5 yourself” (female participant in their 40’s) .
6

7
8 Another common criticism was over the ambiguity of terms such as ‘essential’ and
9
10 ‘emergency’ supplies and services:
11

12
13
14 *I have seen loads of people outside, and I wonder how people will enforce that [penalty fines
15
16 for not social distancing], I’m wondering how can someone prove they are going for an
17
18 ‘emergency reason’? (a male participant in their 30’s)*
19
20

21
22
23 This ambiguity, participants argued, meant that advice was either hard to follow or
24
25 implement, or that “loopholes” could be exploited:
26

27
28
29
30 *Now everyone has been told that they have to stay in their houses, and people are thinking
31
32 well ‘this can be classed as essential, and this can be classed as essential, whereas although
33
34 we have been told a list of things we can do, people are finding loopholes and finding ways to
35
36 get round them (female participant in their 20’s)*
37
38

40 41 **High levels of self-adherence but observations of non-adherence in others**

42
43 All participants reported being highly adherent to government instructions on social
44
45 distancing. Participants described how, despite the perceived lack of clarity discussed above,
46
47 they had been social distancing and isolating as far as possible. Participants also displayed a
48
49 high degree of social consciousness, with many acknowledging that despite not perceiving
50
51 themselves as being at high risk, they were doing it to “save lives” and protect those most
52
53 vulnerable to the disease:
54
55

56
57
58
59 *Staying at home is actually helping to save lives (female participant in their 20’s)*
60

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4
5 *We have been in lockdown for 14 days, and because of my ... grandmother [in her 80s] who*
6 *has health problems, it [going out] is just not worth it. (male participant in their 20's)*
7
8
9

10
11
12 Despite reporting their own high degree of adherence, many participants suggested that they
13 had observed instances of non-adherence in others. Observations of non-adherence were
14 associated with three main factors. First, non-adherence was seen to be due to a lack of
15 social conscience. Participants were generally critical of what they perceived to be a
16 minority of “inconsiderate” individuals:
17
18
19
20
21
22

23
24
25 *I'm worried that people are going to take advantage of the nice weather and ruin it for people*
26 *... Its insane because they have shut the park, but you get some inconsiderate people like a*
27 *group of lads playing football or people taking over the paths. (female participant in their*
28 *40's)*
29
30
31
32
33

34
35
36 This minority of individuals were seen to be flouting guidance related, for example, to public
37 gatherings and not keeping a distance of >2 metres apart from others when out for daily
38 walks or runs:
39
40
41
42
43
44

45 *The canal path we walk along is not 2 metres wide, but you can just about get around it if you*
46 *go on the verge and they go on the verge, and most people do but not everybody does ... I*
47 *don't say anything because ... with all the publicity that's out, if you are still choosing to do*
48 *that, then me telling you not to do it is not going to make a difference, it's frustrating (female*
49 *participant in their 40's)*
50
51
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1
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3 Second, non-adherence was seen to be due to a lack of understanding. For example,
4
5 participants argued that people who were not observing social distancing lacked knowledge
6
7 over how they could help spread the disease even if they themselves were not exhibiting
8
9 symptoms:
10
11

12
13
14 *The vast majority of people are taking it seriously and suffering to a certain extent, but there*
15
16 *is a minority who don't necessarily understand it applies to them also. I know of people who*
17
18 *have gone to parks or gone for a picnic, because they think 'well we don't know anyone who*
19
20 *has any symptoms, and we've not got anything, so we can go about it in the same way'.*
21
22

23 (female participant in their 20's)
24
25

26
27 Third, non-adherence was seen to be due to a lack of enforcement. Many participants were
28
29 critical that police were choosing to enforce social distancing restrictions or were not able to
30
31 (due for example to the ambiguity of terms such as "essential" as discussed in the previous
32
33 section):
34
35

36
37
38 *They say that you are not allowed to go out for non-emergency reasons, which I don't think a*
39
40 *lot of people are observing. People are just going out whenever they want. Those guidelines*
41
42 *are in place by Boris [Johnson; UK Prime Minister] but no-one is really enforcing that. You*
43
44 *see police on the street, but they are not really doing anything.* (male participant in their 30's)
45
46
47
48
49

50 Others discussed how, despite their best efforts, supermarkets appeared to struggle to
51
52 implement social distancing:
53
54

55
56 *The supermarket they are not implementing, what's the point in having the two-metre thing*
57
58 *outside when you can't do that inside. ... I went to the supermarket and people respect it*
59
60

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3 *outside, but as soon as you go inside there is [sic] people, they don't care, they just come*
4
5 *right up to you and try to reach over you.* (female participant in their 40's)
6
7
8
9

10 **Uncertainty around social-reintegration and the future**

11
12 According to participants, “the biggest problem we've got is we don't know when it's going
13
14 to end” and the sense of “powerlessness” this had fostered (male participant in their 50's).

15
16 Despite their high level of current adherence, participants acknowledged there was a limit as
17
18 to how long they and others could adhere, at least without experiencing more severe social
19
20 and psychological suffering. Some participants felt that they would rather be told a specific
21
22 time frame, even if it was far in the future:
23
24

25
26
27
28 *I would rather they [the government] said tonight, 'you're gonna be stuck in your houses*
29
30 *until September, than say, we will review in three weeks, and then say, we will review in three*
31
32 *week, and keep doing that, I'd rather they set a date way in advance in the future because*
33
34 *then you can get your head around it.* (male participant in their 20's)
35
36
37
38

39 Others feared that whilst they and others could “get through” this initial lockdown, having
40
41 multiple lockdowns (a scenario some knew was possible due to the potential for COVID-19
42
43 to re-emerge in a second wave) meant that “people will really struggle mentally”:
44
45
46
47

48 *I've heard on the grapevine and online sources that we are in this lockdown for a few weeks*
49
50 *or so, and then after 12 weeks or so we kind of get released and because we are not all*
51
52 *immune necessarily it all comes back in a wave and then we have this constant thing of being*
53
54 *locked down and then coming out and going back in again, ... and so I think it will go*
55
56 *downhill, that's when people will struggle mentally because they've had that taste of freedom,*
57
58 *and you don't know how long it's all going to finish.* (female participant in their 20's)
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8 Some felt as though they could not look or plan because anticipating social distancing and
9
10 isolation over a period of time was “too overwhelming”:
11
12

13
14 *I'm literally thinking day-by-day, because if one was to consider three months of this, and we*
15 *are only two weeks in, it's just too much, it's too overwhelming.* (a male participant in their
16
17
18
19 50's)
20
21
22

23
24 When looking ahead, participants were divided as to how they felt they, and others, would
25
26 act when social distancing and isolation measures were either relaxed or removed. Some felt
27
28 that they and others would “go back to living my life completely as normal” (male participant
29
30 in their 30's) as soon as possible. These participants spoke of “being desperate to go out and
31
32 go to restaurants or travel a lot” (male participant in their 20's) and generally not taking a
33
34 graded approach to social reintegration. They argued that if they were “told its ok” to
35
36 socially reintegrate, then this was enough for them to “not feel too anxious about going out
37
38 with friends in the future” (male participant in their 30's). Others felt that it would take them
39
40 a longer to return to pre-pandemic social behaviours, and for example felt that they would
41
42 continue to have “anxiety around health” (female participant in their 30's), would be
43
44 “cautious” about a “transition period where I stay in a bit more” (male participant in their
45
46
47
48 30's) and that people in general might remain “socially distant” from one another:
49
50
51

52
53 *People are not going to stay like this for another 6 months. It's for a good reason I know, but*
54 *it's like a prison, we know what people are suffering mentally and emotionally, we don't*
55
56
57 *know what people are going through behind their door ... When all this comes to an end we*
58
59
60

1
2
3 *don't know how life is going to be. Is everybody going to be socially distant? It's scary.*

4
5 (female participant in their 30's)

6
7
8
9
10 Others argued that how they would act would likely depend on the circumstances under
11 which social distancing and isolation measures were being relaxed or removed. Specifically,
12 this was tied to their perception of whether COVID-19 still posed a risk to them or to society
13 in general. They argued that, if a vaccine was available, then they would be happy to return
14 to their pre-pandemic activity.
15
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18
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20 21 22 23 **Alternative accounts and positive perceptions resulting from social distancing and** 24 **isolation**

25
26 Although the findings discussed above represent the most common views exhibited by
27 participants, negative case analysis did reveal some alternative accounts. For example, some
28 participants argued that social distancing and isolation “hadn't been hard” (male participant
29 in their 20's). However, these participants were all university students, and acknowledged
30 that part of the reason social distancing hadn't been as difficult for them was there had been
31 no loss of income and, less loss of routine for them (although they had experienced other
32 challenges, for example, related to added university-related stress caused by uncertainty) .
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44 A small number of participants argued that they were able to draw positives from the
45 social distancing and isolation due to COVID-19. For example, some described how
46 household quarantine had meant they could have “more time with their children” (male
47 participant in their 30's) or had brought family units together (male participant in their 50's).
48
49 However, those participants who explicitly discussed the positives to be drawn from social
50 distancing and isolation were all from higher socio-economic backgrounds, and tended to live
51 in more rural or less densely populated areas of the UK.
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DISCUSSION

Our findings have explored ways in which many of our participants may be experiencing feelings of anxiety, depression and loss as a result of COVID-19 social distancing and isolation. . The social and psychological impacts identified through this study centred around our key theme of ‘loss’.. Practical social and economic losses - the loss of (in-person) social interaction, loss of income and loss of structure and routine – led to psychological and emotional losses – the loss of motivation, loss of meaning, and loss of self-worth. Findings also suggest that participants generally found information on social distancing to be ambiguous. However, there were differing views as to whether the government was at fault (insufficiently clear communication) or that the terms themselves are ambiguous and a small minority of the UK public were taking advantage of the ambiguity. It was recognized that this ambiguity may have been designed to permit greater social freedom than the more extreme social distancing and isolation measures implemented in other countries. Additionally, there was universally high adherence to social distancing and isolation guidelines reported across the study sample, yet most participants had observed or heard of non-adherence in others. Participants were highly critical of such instances of non-adherence, citing lack of social conscience, lack of understanding and lack of enforcement as likely causes. Perhaps the greatest concern for participants was the uncertainty they faced over the duration of the social distancing and isolation measures, as well as their ability to cope longer-term. There was also uncertainty as to how they and others would act, with some fearful of lingering inhibitions and anxiety over social contact and health, and others eager to return to normal levels of social activity.

Relevance to existing literature

1
2
3 Our findings on COVID-19 social distancing and isolation support some of the findings from
4 existing systematic reviews on previous pandemics related to influenza and SARS.[6-7] For
5 instance, we found that frustration or anxiety over loss of social interaction or loss of income,
6 inadequate or ambiguous information, and fears over the duration of social distancing and
7 isolation measures were all major themes.[6-8] However, contrary to previous research
8 which suggests that adherence with pandemic NPIs is lower in instances where people have
9 low trust in government and where people perceive themselves at relatively low risk from the
10 disease,[7] our participants were highly adherent to social distancing and isolation measures,
11 despite many lacking trust in government and perceiving themselves at low risk. In fact,
12 stigma was more likely to be attributed to those who were failing to socially distance and
13 isolate. Of course, as noted above the scale and severity of the pandemic and subsequent
14 measures are unprecedented. As such, although there is existing research on its likely
15 effects,[6] and although quantitative research is starting to emerge,[11] there is to, our
16 knowledge, no published qualitative evidence on public perceptions and experiences of the
17 psychological and social public experiences of COVID-19 related social distancing and
18 isolation, and its relation to adherence – a gap this study addresses.

41 **Limitations**

42 One limitation of this study is that it is not possible to rule out that the high degree of
43 adherence and social conscience that participants expressed was not at least partly affected by
44 social desirability bias, which can often be encountered in focus group studies.[19] However,
45 conducting focus groups online has been found to reduce social desirability bias (although it
46 is worth noting that this is more so where asynchronous or text-only communication is used,
47 and not video-conferencing as in our study).[12,20]

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3 Another limitation is that the sample was not as diverse as was desired, in terms of
4 ethnicity, with a number of ethnicities (including those from Black or Black British
5 ethnicities) not represented. This was due to the fact that no participants from these ethnic
6 ethnicities) not represented. This was due to the fact that no participants from these ethnic
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8 ethnicities) not represented. This was due to the fact that no participants from these ethnic
9 ethnicities) not represented. This was due to the fact that no participants from these ethnic
10 groups applied to take part in the study. Future research will seek to recruit a more ethnically
11 diverse sample. Also, this study did not recruit participants who are deemed at particularly
12 high risk from COVID-19-related complications, for example, individuals aged 70 and over
13 and those living with certain chronic health conditions (no participants were aged over 60
14 years old).[21] Because these individuals are likely to have been significantly affected by
15 social distancing and isolation policy (being required to self-isolate for 12 weeks), their views
16 will be important. It is also worth noting that our recruitment material did encourage those at
17 high risk to apply, though we received no applications from those over-70. This may be
18 partly due to the fact that those over-70 are a hard-to-reach group online, because they are
19 significantly less likely to use social media or be heavy internet users,[22] which, due to the
20 lack of online social support and interaction, might mean they are at particularly high risk of
21 some of the negative social and psychological impacts discussed in this paper. Future
22 research will explore at-risk groups' experiences in depth. Future papers will also explore
23 further the similarities and differences in views and experiences in the perceptions of
24 experiences of participants living in different parts of the UK (e.g. London compared to less
25 densely populated areas), a theme only briefly discussed here due to limitations of scope.
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49 **Implications for policy and practice**

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51 This study suggests that for some, the social distancing and isolation associated with COVID-
52 19 policy may have had negative impacts on mental health and wellbeing. The prevalence of
53 COVID-19-related depression and anxiety, and the extent to which it will last beyond the
54 removal or relaxation of social distancing and isolation policies remains to be seen. Our
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3 ongoing research will explore these social and psychological impacts longitudinally.
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5 Policymakers and the public health community must discuss measures to respond to the
6
7 likely wave of mental ill-health which is expected to follow, and which is tentatively
8
9 suggested by our early qualitative evidence. The theme of loss and addressing public
10
11 concerns around physical and emotional losses (e.g. meaning and self-worth), may inform
12
13 current and future therapeutic interventions. Loss of meaning and self-worth may be due in
14
15 part to loss of control, and increasing a sense of control for the public should be considered in
16
17 future policy, intervention, and programming.[23] Additionally, findings suggest that a rapid
18
19 response is necessary in terms of public health programming to mitigate these mental health
20
21 impacts. Waiting until restrictions and isolation measures are relaxed or removed to provide
22
23 support services could potentially have devastating impacts. Government and the public
24
25 health authorities should look at ways of extending mental health outreach services,
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27 especially remotely.[24] Timely attention is needed for those who are predisposed to
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29 depression and anxiety, those who may be suicidal, and those experiencing significant social,
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31 economic and personal loss.
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38 Our study also suggests that although the COVID-19 pandemic has disproportionately
39
40 negatively affected those in low-paid or precarious employment. Future research and policy
41
42 should therefore seek to develop measures that specifically seek to remediate the social,
43
44 economic and psychological harms related to COVID-19 as experienced by those from
45
46 disadvantaged backgrounds. Looking ahead to later stages in the current pandemic, or to the
47
48 development of pandemic preparedness programmes for the future, a couple of lessons can be
49
50 distilled, which warrant urgent attention. Firstly, initial high levels of support for, and
51
52 adherence to, social distancing and isolation measures are likely to wane over time,
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54 particularly where end dates are and remain uncertain. Secondly, in planning the ‘exit
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56 strategy’ for the UK lockdown, and its possible impact on future resurgences of COVID-19
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3 infection, policymakers and public health authorities need to account for the fact that,
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5 although some individuals will voluntarily or habitually continue to socially distance (graded
6
7 social reintegration) others will seek immediately to re-integrate fully beyond what they are
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9 permitted to.
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58 DECLARATIONS

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34 manuscript is an honest, accurate, and transparent account of the study being reported; that no
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36 as planned (and, if relevant, registered) have been explained.
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13
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17
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Standards for Reporting Qualitative Research (SQRQ) Checklist

(NB: page and line numbers refer to the clean manuscript document (PDF))

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| | Other | | |
| S20 | Conflicts of interest | 28 | 17-29 |
| S21 | Funding | 28, 29 | 56-59, 3-8 |

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3 **Public perceptions and experiences of social distancing and social isolation**
4 **during the COVID-19 pandemic: A UK-based focus group study.**
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ABSTRACT

OBJECTIVE: This study explored UK public perceptions and experiences of social distancing and social isolation related to the COVID-19 pandemic.

DESIGN: This qualitative study comprised five focus groups, carried out online during the early stages of the UK's stay at home order ('lockdown'), and analysed using a thematic approach.

SETTING: Focus groups took place via online video-conferencing

PARTICIPANTS: Participants (n=27) were all UK residents aged 18 years and older, representing a range of gender, ethnic, age and occupational backgrounds.

RESULTS: Qualitative analysis revealed four main themes: (1) Loss – participants' loss of (in-person) social interaction, loss of income and loss of structure and routine led to psychological and emotional 'losses' such as loss of motivation, loss of meaning, and loss of self-worth; (2) Criticisms of government communication – participants reported a lack of trust in government and a lack of clarity in the guidelines around social distancing and isolation; (3) Adherence – participants reported high self-adherence to social distancing guidelines but reported seeing or hearing of non-adherence in others; (4) Uncertainty around social-reintegration and the future - some participants felt they would have lingering concerns over social contact while others were eager to return to high levels of social activity.

Most participants, and particularly those in low-paid or precarious employment, reported feeling that the social distancing and isolation associated with COVID-19 policy has had negative impacts on their mental health and wellbeing during the early stages of the UK's 'lockdown'.

CONCLUSIONS: A rapid response is necessary in terms of public health programming to mitigate the mental health impacts of COVID-19 social distancing and isolation. Social

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3 distancing and isolation ‘exit strategies’ must account for the fact that, although some
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5 individuals will voluntarily or habitually continue to socially distance, others will seek high
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7 levels of social engagement as soon as possible.
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11 12 **Strengths and limitations of this study**

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17 • A strength of this study is that it can help to inform social distancing and
18 isolation ‘exit strategies’, since it provides evidence of how people are likely to
19 behave when these measures are removed or relaxed.
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23 • Another strength of this study is that it is the first qualitative study of its kind to
24 provide evidence on the current mental health impacts of COVID-19 related social
25 distancing and isolation.
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29 • Another strength is its finding of the various forms of ‘loss’ as a new concept
30 through which to understand the practical and emotional impacts of social
31 distancing and isolation on the public.
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35 • A limitation of this study is that it does not include participants from vulnerable or
36 ‘high-risk’ groups (e.g. over-70s).
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INTRODUCTION

The current coronavirus (COVID-19) pandemic presents a considerable challenge to public health in the UK and globally.[1-2] Pandemics are problematic for clinical and public health agencies and policymakers because of the scientific and medical uncertainty that accompanies novel viruses like COVID-19.[3] Since COVID-19 is a new virus, pharmaceutical interventions like vaccines are not presently available. Public health policy is therefore exclusively reliant on non-pharmaceutical interventions (NPIs). The key NPIs being used in relation to the COVID-19 pandemic in the UK and globally (in addition to personal hygiene advisories (e.g. emphasising regular and thorough handwashing) are *social distancing* and *social isolation*. Social distancing (physical distancing) in the UK has included the banning of public gatherings, closure of schools and all non-essential shops, workplaces and services, and the recommendation of keeping a distance of >2 metres apart from others.[4] Social isolation (self isolation) guidelines in the UK have included a period of 7 days quarantine for those showing symptoms of, or testing positive for, COVID-19, and a 14 day quarantine period for others in the same household (although specific guidelines have varied over time)).[4]

Due to the extent of the social distancing and social isolation measures being implemented in response to COVID-19, social and psychological impacts on the public are anticipated and warrant further attention.[5]. A recent rapid review of the psychological impact of quarantine found that longer quarantine duration, infection fears, frustration and boredom, inadequate supplies, inadequate information, financial loss and stigma were among the major stressors.[6] Another systematic review of the literature on NPIs in relation to pandemic influenza and SARS found that people actively evaluate NPIs in terms of criteria such as perceived necessity, efficacy, acceptability and feasibility.[7] Public views on social

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3 distancing and social isolation are ambivalent in some contexts because of their perceived
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5 adverse social and economic impacts and their ability to attract stigma, particularly amongst
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7 those required to self-isolate.[7] Existing research on social distancing and isolation
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9 highlights a number of challenges for public health policymakers, including a lack of trust in
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11 government;[8] concerns over strains in family resources;[8] gaps and confusions in some
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13 areas of pandemic information communication;[9] and low adherence to voluntary social
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15 isolation and relatively low adherence to non-attendance at public gatherings.[10] Although
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17 there is existing research from past pandemics on its likely effects,[6] and new quantitative
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19 research is starting to emerge,[11] there is to our knowledge no published qualitative
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21 evidence on public perceptions and experiences of the psychological and social impacts of
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23 COVID-19-related social distancing and social isolation, and its relation to adherence. The
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25 present study seeks to address this gap.
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31 This study explored four main questions: (1) What are the social and psychological
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33 impacts of social distancing and isolation experienced by participants during the COVID-19
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35 pandemic? (2) What are participants' views on government communication around social
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37 distancing and isolation? (3) What are participants' current experiences of adherence in
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39 relation to social distancing and isolation? (4) What are participants' views on the future in
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41 regard to COVID-19 social distancing and isolation? This study therefore aims to contribute
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43 to knowledge on adherence to social distancing and isolation policy to provide insight into
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45 how communication with the public on social distancing and isolation may be shaped and
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47 improved in the future.
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54 **PARTICIPANTS AND METHODS**

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56 Five online focus groups with 27 participants were run between March 28th and April 4th,
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58 2020. Data were collected 5-12 days after the UK government's 'stay at home'
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announcement on the 23rd March 2020, where people were advised to leave their houses only: to shop for basic necessities, take one form of exercise per day, for medical needs, or travelling to work only when necessary and where home working was not possible.

Participants were all adults aged 18 years or over currently residing in the UK. Participants were recruited from all four UK countries (England, Wales, Scotland and Northern Ireland). Under normal circumstances, online focus groups can be a useful way of eliciting public views related to matters of health and medicine, particularly from diverse and geographically dispersed participants [12-13] but were necessary due to social isolation policy. Participants gave both verbal and written informed consent. Ethical approval was received by Swansea University's School of Management Research Ethics Committee.

Purposive sampling was used to provide a diverse range of ages, genders, race/ethnicities and social backgrounds (Table 1).[14-15] Researchers used a combination of social media snowball sampling, online community and volunteer advertising sites and social media advertisements (Facebook ads). However, the final sample did consist of a large proportion of white participants and participants aged under 45 years (see limitations section for further discussion). Due to social distancing measures, it was necessary for all recruitment to be conducted online.

Table 1: Demographic details reported by participants.

| Characteristic | N (%) |
|------------------|---------|
| <i>Gender</i> | |
| Female | 13 (48) |
| Male | 14 (52) |
| <i>Age range</i> | |

| | |
|--------------------------------------------------|---------|
| 18-24 | 7 (26) |
| 25-34 | 6 (22) |
| 35-44 | 8 (30) |
| 45+ | 6 (22) |
| <i>Ethnicity</i> | |
| White - British | 16 (59) |
| White – any other White background | 6 (22) |
| Asian or Asian British - Pakistani | 3 (11) |
| Mixed – White and Asian | 1 (4) |
| Other | 1 (4) |
| <i>Occupational Classification</i> | |
| Managers, directors and senior officials | 2 (7) |
| Professional occupations | 6 (22) |
| Associate professional and technical occupations | 5 (19) |
| Administrative and secretarial occupations | 1 (4) |
| Skilled trades occupations | 1 (4) |
| Caring, leisure and other service occupations | 1 (4) |
| Sales and customer service occupations | 3 (11) |
| Elementary occupations | 1 (4) |
| Full-time student | 5 (19) |
| Unclassified/occupation not provided | 2 (7) |

Note: occupational classifications coded using the Office for National Statistics (ONS) Occupation

Coding Tool.

To ensure that online discussion was manageable, focus groups were kept to between 5-8 participants. Each group met virtually via a web video-conferencing platform (Zoom) for

1
2
3 between 60-90 minutes. Participants joined using both video and audio. All focus groups
4
5 were organised and moderated by SW . The topic guide for the focus groups was initially
6
7 developed using existing literature on public attitudes and experiences in past pandemics and
8
9 was tested and refined in a pilot focus group. The main topics for the focus groups were:
10
11 general views on social distancing and isolation; health impacts of social distancing and
12
13 isolation; views on government COVID-19 advice and communication; and views on
14
15 compliance with, and the future impacts of, social distancing and isolation.
16
17
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21

22 **Analysis**

23
24 Data collection and analysis followed an iterative process, whereby emergent themes from
25
26 early focus groups were used to add to or refine questions during subsequent focus groups.
27
28 All focus groups were audio recorded and transcribed for coding. SW and KD analysed the
29
30 transcripts and developed and applied the thematic coding framework. Themes were
31
32 discussed and further developed with CA and TT during virtual research group meetings. To
33
34 help analysis we looked to validate “sensitive moments” between groups that indicated
35
36 difficult but important issues.[16] Negative case analysis was used to seek for information
37
38 that did not fit emergent themes, and where this occurred, themes were modified
39
40 accordingly.[17] Analysis followed a thematic approach as described by Coffey and
41
42 Atkinson.[18] Here data analysis takes a pragmatic approach, whereby initial broad research
43
44 questions inform the abductive generation of themes.[18] Initial primary (open) codes was
45
46 developed, and were then developed and connected to other related themes to form
47
48 overarching secondary codes that were developed into the four themes described
49
50 below.[14,18] Data collection and analysis continued until saturation occurred (that is, until
51
52 no new significant themes emerged).[18] Data were analysed in NVivo (version 11.4.3,
53
54 QRS).
55
56
57
58
59
60

Patient and Public Involvement

No patients were involved in this study. The public were not involved in the development of the research questions, research design or outcome measures. A pilot focus group with participants not included in the present paper was used to help test and refine the focus group questions. Summary results were disseminated via email to participants prior to publication for feedback and comment.

RESULTS

Analysis revealed four broad themes: (1) Loss (2) Lack of trust in, and clarity of, government communication around social distancing and isolation (3) High levels of self-adherence but observations of non-adherence in others; and (4) Uncertainty around social-reintegration and the future. Within each broad theme were a number of substantive sub-themes that are discussed below, supplemented by indicative quotes..

Loss

Many participants felt that the social distancing and isolation policies had had significant social and psychological impacts on their lives, central to which was a feeling of loss. This experience of loss, which one participant likened to a process of “grieving” (male participant in their 40’s), consisted of three practical social and economic losses: loss of (in-person) social interaction, loss of income, and loss of structure and routine. These in turn led to three psychological and emotional “losses”: loss of motivation, loss of meaning, and loss of self-worth.

1
2
3 First, participants spoke of a loss of social interaction. The suddenness and
4
5 extensiveness of the lack of face-to-face contact had, even after only one week of lockdown,
6
7 already “taken its toll”, leaving participants feeling “alienated”:
8
9

10
11
12 *I've been working at home for the past week and a bit and it's taken its toll ... because you*
13
14 *think social contact is such an important part of everyday life and now it's like you walk*
15
16 *down the street and people are almost too scared to walk too close. It's so alien. (male*
17
18 *participant in their 20's)*
19

20
21
22
23 A number talked about feeling depressed or anxious as a result of social distancing or
24
25 isolation, an experience some likened to “a prison” (a female participant in their 30's) or
26
27 feeling emotionally “claustrophobic”:
28
29

30
31
32 *It's all over the news, it's all over your phone, it's all over the TV, it's basically everywhere*
33
34 *you turn you are hearing about it. All of a sudden, we can't do these things we used to do, like*
35
36 *going to the shops and restaurants, and we just have to stay in, and I think people feel*
37
38 *claustrophobic in both a physical and an emotional sense. (male participant in their 20's)*
39
40

41
42
43 Second, a number of participants discussed how a loss of income, either through permanent
44
45 loss of a job, or through temporary loss (via lost clients or customers or being furloughed),
46
47 had left them feeling “quite depressed” (female participant in their 30's).
48
49

50
51 Third, participants expressed of a loss of structure and routine, which for some had
52
53 left them feeling “less active” or “sluggish”:
54
55

56
57 *I feel really lazy at home. I feel sluggish. I feel out of my routine. I feel much less active, both*
58
59 *mentally and physically. You know, not taking the trip to work every day. My working from*
60

1
2
3 *home schedule is neither here nor there. Mentally I am not as sharp, I feel like I am taking*
4
5 *lots of naps in the day. (male participant in their 20's)*
6
7
8
9

10 The inability to go to work, or for some the significant re-structuring of work patterns,
11 including balancing home working with home schooling, combined with worry over the virus
12 itself, meant that many participants felt “overwhelmed” or “scared”:
13
14
15

16
17
18
19 *I'm literally planning day-to-day as things go along. ... I'm not used to having the kids every*
20 *single day because they are usually at school. It's difficult to work around them, I can't do*
21 *anything with them, because I can't go out. I feel so scared and don't want to risk it (female*
22 *participant in their 30's)*
23
24
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30 Participants discussed how impacts like losing their job or not being able to go to work, and
31 not being able to socialise with friends, meant they experienced a general loss of meaning in
32 life:
33
34
35

36
37
38 *Being locked in a room trying to find something meaningful to do during the day, and I think*
39 *it's had a severe impact ... I hope something changes within a few weeks, so I am able to go*
40 *out and live a fulfilling life (male participant in their 30's)*
41
42
43
44
45
46

47 One participant already felt in need of professional mental health support, less than two
48 weeks into isolation:
49
50
51

52
53
54 *All this talk about social distancing and things is so depressing, terrible, I mean I have even*
55 *been contemplating on contacting The Samaritans just to be able to try to get through all this.*
56
57
58 *(male participant in their 30's)*
59
60

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5 Participants also spoke of a loss of motivation to perform basic everyday tasks, such as
6 personal hygiene and grooming or exercising, and how this demotivation was having an
7
8 effect on their physical health:
9
10
11
12
13

14 *Physically it has had a toll on people. All day you are stuck at home. You eat, you sleep, you*
15 *work, its gonna have an effect on the body, there is no real drive or motivation.”* (a male
16
17 participant in their 20’s)
18
19
20
21
22

23 For some, this lack of motivation had left them feeling “low” or “depressed”:
24
25
26

27 *We are feeling very down and demotivated, very low very depressed to some extent... it’s*
28 *become more stressful to get by and function on a daily basis.* (male participant in their 30’s)
29
30
31
32
33

34 Finally, participants suggested that an inability to socialise and the loss of social support led
35
36 to them feeling a loss of ‘self-worth’:
37
38
39
40

41 *Your self-worth goes down a bit, because you can’t socialise with people and make yourself*
42 *feel good about yourself.* (male participant in their 30’s)
43
44
45
46
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48 These emotional and psychological losses were particularly acute for those living in more
49 urban, densely-populated cities like London or Birmingham. They were also especially
50 evident amongst those in low-paid or precarious occupations, who had either lost their job or
51 income or were now relying on parental, familial or state financial support as a result of the
52 pandemic:
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1
2
3 *The company I work for has closed down and I have had to apply for welfare assistance ...*
4
5 *and I've had to go and live with my parents now, and they have had to support me financially.*
6
7 *... it's been difficult, the whole mental health, the ability to function and get by, and being*
8
9 *constantly locked in.* (male participant in their 30's)
10
11
12
13

14 **Lack of trust in, and clarity of, government communication around social distancing** 15 16 **and isolation**

17
18 Most participants felt that guidance on social distancing and isolation had been generally
19
20 unclear, and that information about the pandemic had conveyed “mixed messages”:
21
22

23
24
25 *After reading several news publications and channels, there has been much campaign around*
26
27 *social distancing, and with isolation you normally associate it when you have got the virus*
28
29 *yourself, but I think over the past week there have been several mixed messages over social*
30
31 *distancing* (male participant in their 30's)
32
33
34
35

36 Many participants described a lack of trust either in government, who were seen to be
37
38 “politicising” the pandemic:
39
40
41

42
43 *I'm trying to pick my way through what is happening, a lot of politicians are politicising it*
44
45 *[COVID-19] and when you read the internet, it is very difficult to know what is real, true or*
46
47 *valid, even if you read a broad church of views, facts and figures, it is still very difficult to*
48
49 *make sense of it all.* (male participant in their 50's)
50
51
52

53 As noted in the previous section, some participants found that being locked at home coupled
54
55 with constant media and social media attention on COVID-19 made them feel
56
57 “claustrophobic in both a physical and an emotional sense” (male participant in their 20's),
58
59
60

1
2
3 and that “seeing others in a heightened state of anxiety makes it harder to suppress that in
4
5 yourself” (female participant in their 40’s) .
6

7
8 Another common criticism was over the ambiguity of terms such as ‘essential’ and
9
10 ‘emergency’ supplies and services:
11

12
13
14 *I have seen loads of people outside, and I wonder how people will enforce that [penalty fines
15
16 for not social distancing], I’m wondering how can someone prove they are going for an
17
18 ‘emergency reason’? (a male participant in their 30’s)*
19
20

21
22
23 This ambiguity, participants argued, meant that advice was either hard to follow or
24
25 implement, or that “loopholes” could be exploited:
26

27
28
29 *Now everyone has been told that they have to stay in their houses, and people are thinking
30
31 well ‘this can be classed as essential, and this can be classed as essential, whereas although
32
33 we have been told a list of things we can do, people are finding loopholes and finding ways to
34
35 get round them (female participant in their 20’s)*
36
37

40 41 **High levels of self-adherence but observations of non-adherence in others**

42
43 All participants reported being highly adherent to government instructions on social
44
45 distancing. Participants described how, despite the perceived lack of clarity discussed above,
46
47 they had been social distancing and isolating as far as possible. Participants also displayed a
48
49 high degree of social consciousness, with many acknowledging that despite not perceiving
50
51 themselves as being at high risk, they were doing it to “save lives” and protect those most
52
53 vulnerable to the disease:
54
55

56
57
58
59 *Staying at home is actually helping to save lives (female participant in their 20’s)*
60

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5 *We have been in lockdown for 14 days, and because of my ... grandmother [in her 80s] who*
6 *has health problems, it [going out] is just not worth it. (male participant in their 20's)*
7
8
9

10
11
12 Despite reporting their own high degree of adherence, many participants suggested that they
13 had observed instances of non-adherence in others. Observations of non-adherence were
14 associated with three main factors. First, non-adherence was seen to be due to a lack of
15 social conscience. Participants were generally critical of what they perceived to be a
16 minority of “inconsiderate” individuals:
17
18
19
20
21
22

23
24
25 *I'm worried that people are going to take advantage of the nice weather and ruin it for people*
26 *... Its insane because they have shut the park, but you get some inconsiderate people like a*
27 *group of lads playing football or people taking over the paths. (female participant in their*
28 *40's)*
29
30
31
32
33

34
35
36 This minority of individuals were seen to be flouting guidance related, for example, to public
37 gatherings and not keeping a distance of >2 metres apart from others when out for daily
38 walks or runs:
39
40
41
42
43
44

45 *The canal path we walk along is not 2 metres wide, but you can just about get around it if you*
46 *go on the verge and they go on the verge, and most people do but not everybody does ... I*
47 *don't say anything because ... with all the publicity that's out, if you are still choosing to do*
48 *that, then me telling you not to do it is not going to make a difference, it's frustrating (female*
49 *participant in their 40's)*
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3 Second, non-adherence was seen to be due to a lack of understanding. For example,
4
5 participants argued that people who were not observing social distancing lacked knowledge
6
7 over how they could help spread the disease even if they themselves were not exhibiting
8
9 symptoms:
10
11

12
13
14 *The vast majority of people are taking it seriously and suffering to a certain extent, but there*
15
16 *is a minority who don't necessarily understand it applies to them also. I know of people who*
17
18 *have gone to parks or gone for a picnic, because they think 'well we don't know anyone who*
19
20 *has any symptoms, and we've not got anything, so we can go about it in the same way'.*
21
22

23 (female participant in their 20's)
24
25
26

27
28 Third, non-adherence was seen to be due to a lack of enforcement. Many participants were
29
30 critical that police were choosing to enforce social distancing restrictions or were not able to
31
32 (due for example to the ambiguity of terms such as "essential" as discussed in the previous
33
34 section):
35
36
37

38
39 *They say that you are not allowed to go out for non-emergency reasons, which I don't think a*
40
41 *lot of people are observing. People are just going out whenever they want. Those guidelines*
42
43 *are in place ... but no-one is really enforcing that. You see police on the street, but they are*
44
45 *not really doing anything.* (male participant in their 30's)
46
47
48

49
50 Others discussed how, despite their best efforts, supermarkets appeared to struggle to
51
52 implement social distancing:
53
54
55

56
57 *The supermarket they are not implementing, what's the point in having the two-metre thing*
58
59 *outside when you can't do that inside. ... I went to the supermarket and people respect it*
60

1
2
3 *outside, but as soon as you go inside there is [sic] people, they don't care, they just come*
4
5 *right up to you and try to reach over you. (female participant in their 40's)*
6
7
8
9

10 **Uncertainty around social-reintegration and the future**

11
12 According to participants, “the biggest problem we've got is we don't know when it's going
13
14 to end” and the sense of “powerlessness” this had fostered (male participant in their 50's).

15
16 Despite their high level of current adherence, participants acknowledged there was a limit as
17
18 to how long they and others could adhere, at least without experiencing more severe social
19
20 and psychological suffering. Some participants felt that they would rather be told a specific
21
22 time frame, even if it was far in the future:
23
24

25
26
27
28 *I would rather they [the government] said tonight, 'you're gonna be stuck in your houses*
29
30 *until September, than say, we will review in three weeks, and then say, we will review in three*
31
32 *week, and keep doing that, I'd rather they set a date way in advance in the future because*
33
34 *then you can get your head around it. (male participant in their 20's)*
35
36
37
38

39 Others feared that whilst they and others could “get through” this initial lockdown, having
40
41 multiple lockdowns (a scenario some knew was possible due to the potential for COVID-19
42
43 to re-emerge in a second wave) meant that “people will really struggle mentally”:
44
45
46
47

48 *I've heard on the grapevine and online sources that we are in this lockdown for a few weeks*
49
50 *or so, and then after 12 weeks or so we kind of get released and because we are not all*
51
52 *immune necessarily it all comes back in a wave and then we have this constant thing of being*
53
54 *locked down and then coming out and going back in again, ... and so I think it will go*
55
56 *downhill, that's when people will struggle mentally because they've had that taste of freedom,*
57
58 *and you don't know how long it's all going to finish. (female participant in their 20's)*
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8 Some felt as though they could not look or plan because anticipating social distancing and
9
10 isolation over a period of time was “too overwhelming”:
11
12
13

14 *I'm literally thinking day-by-day, because if one was to consider three months of this, and we*
15 *are only two weeks in, it's just too much, it's too overwhelming.* (a male participant in their
16
17
18
19 50's)
20
21
22

23
24 When looking ahead, participants were divided as to how they felt they, and others, would
25
26 act when social distancing and isolation measures were either relaxed or removed. Some felt
27
28 that they and others would “go back to living my life completely as normal” (male participant
29
30 in their 30's) as soon as possible. These participants spoke of “being desperate to go out and
31
32 go to restaurants or travel a lot” (male participant in their 20's) and generally not taking a
33
34 graded approach to social reintegration. They argued that if they were “told its ok” to
35
36 socially reintegrate, then this was enough for them to “not feel too anxious about going out
37
38 with friends in the future” (male participant in their 30's). Others felt that it would take them
39
40 a longer to return to pre-pandemic social behaviours, and for example felt that they would
41
42 continue to have “anxiety around health” (female participant in their 30's), would be
43
44 “cautious” about a “transition period where I stay in a bit more” (male participant in their
45
46
47
48 30's) and that people in general might remain “socially distant” from one another:
49
50
51

52
53 *People are not going to stay like this for another 6 months. It's for a good reason I know, but*
54 *it's like a prison, we know what people are suffering mentally and emotionally, we don't*
55
56
57 *know what people are going through behind their door ... When all this comes to an end we*
58
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60

1
2
3 *don't know how life is going to be. Is everybody going to be socially distant? It's scary.*

4
5 (female participant in their 30's)

6
7
8
9
10 Others argued that how they would act would likely depend on the circumstances under
11 which social distancing and isolation measures were being relaxed or removed. Specifically,
12 this was tied to their perception of whether COVID-19 still posed a risk to them or to society
13 in general. They argued that, if a vaccine was available, then they would be happy to return
14 to their pre-pandemic activity.
15
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20 21 22 23 **Alternative accounts and positive perceptions resulting from social distancing and** 24 **isolation**

25
26 Although the findings discussed above represent the most common views exhibited by
27 participants, negative case analysis did reveal some alternative accounts. For example, some
28 participants argued that social distancing and isolation “hadn't been hard” (male participant
29 in their 20's). However, these participants were all university students, and acknowledged
30 that part of the reason social distancing hadn't been as difficult for them was there had been
31 no loss of income and, less loss of routine for them (although they had experienced other
32 challenges, for example, related to added university-related stress caused by uncertainty) .
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44 A small number of participants argued that they were able to draw positives from the
45 social distancing and isolation due to COVID-19. For example, some described how
46 household quarantine had meant they could have “more time with their children” (male
47 participant in their 30's) or had brought family units together (male participant in their 50's).
48
49 However, those participants who explicitly discussed the positives to be drawn from social
50 distancing and isolation were all from higher socio-economic backgrounds, and tended to live
51 in more rural or less densely populated areas of the UK.
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DISCUSSION

Our findings have explored ways in which many of our participants may be experiencing feelings of anxiety, depression and loss as a result of COVID-19 social distancing and isolation. . The social and psychological impacts identified through this study centred around our key theme of ‘loss’.. Practical social and economic losses - the loss of (in-person) social interaction, loss of income and loss of structure and routine – led to psychological and emotional losses – the loss of motivation, loss of meaning, and loss of self-worth. Findings also suggest that participants generally found information on social distancing to be ambiguous. However, there were differing views as to whether the government was at fault (insufficiently clear communication) or that the terms themselves are ambiguous and a small minority of the UK public were taking advantage of the ambiguity. It was recognized that this ambiguity may have been designed to permit greater social freedom than the more extreme social distancing and isolation measures implemented in other countries. Additionally, there was universally high adherence to social distancing and isolation guidelines reported across the study sample, yet most participants had observed or heard of non-adherence in others. Participants were highly critical of such instances of non-adherence, citing lack of social conscience, lack of understanding and lack of enforcement as likely causes. Perhaps the greatest concern for participants was the uncertainty they faced over the duration of the social distancing and isolation measures, as well as their ability to cope longer-term. There was also uncertainty as to how they and others would act, with some fearful of lingering inhibitions and anxiety over social contact and health, and others eager to return to normal levels of social activity.

Relevance to existing literature

1
2
3 Our findings on COVID-19 social distancing and isolation support some of the findings from
4 existing systematic reviews on previous pandemics related to influenza and SARS.[6-7] For
5 instance, we found that frustration or anxiety over loss of social interaction or loss of income,
6 inadequate or ambiguous information, and fears over the duration of social distancing and
7 isolation measures were all major themes.[6-8] However, contrary to previous research
8 which suggests that adherence with pandemic NPIs is lower in instances where people have
9 low trust in government and where people perceive themselves at relatively low risk from the
10 disease,[7] our participants were highly adherent to social distancing and isolation measures,
11 despite many lacking trust in government and perceiving themselves at low risk. In fact,
12 stigma was more likely to be attributed to those who were failing to socially distance and
13 isolate. Of course, as noted above the scale and severity of the pandemic and subsequent
14 measures are unprecedented. As such, although there is existing research on its likely
15 effects,[6] and although quantitative research is starting to emerge,[11] there is to, our
16 knowledge, no published qualitative evidence on public perceptions and experiences of the
17 psychological and social public experiences of COVID-19 related social distancing and
18 isolation, and its relation to adherence – a gap this study addresses.

41 **Limitations**

42 One limitation of this study is that it is not possible to rule out that the high degree of
43 adherence and social conscience that participants expressed was not at least partly affected by
44 social desirability bias, which can often be encountered in focus group studies.[19] However,
45 conducting focus groups online has been found to reduce social desirability bias (although it
46 is worth noting that this is more so where asynchronous or text-only communication is used,
47 and not video-conferencing as in our study).[12,20]

1
2
3 Another limitation is that the sample was not as diverse as was desired, in terms of
4 ethnicity, with a number of ethnicities (including those from Black or Black British
5 ethnicities) not represented. This was due to the fact that no participants from these ethnic
6 ethnicities) not represented. This was due to the fact that no participants from these ethnic
7 ethnicities) not represented. This was due to the fact that no participants from these ethnic
8 ethnicities) not represented. This was due to the fact that no participants from these ethnic
9 ethnicities) not represented. This was due to the fact that no participants from these ethnic
10 groups applied to take part in the study. Future research will seek to recruit a more ethnically
11 diverse sample. Also, this study did not recruit participants who are deemed at particularly
12 high risk from COVID-19-related complications, for example, individuals aged 70 and over
13 and those living with certain chronic health conditions (no participants were aged over 60
14 years old).[21] Because these individuals are likely to have been significantly affected by
15 social distancing and isolation policy (being required to self-isolate for 12 weeks), their views
16 will be important. It is also worth noting that our recruitment material did encourage those at
17 high risk to apply, though we received no applications from those over-70. This may be
18 partly due to the fact that those over-70 are a hard-to-reach group online, because they are
19 significantly less likely to use social media or be heavy internet users,[22] which, due to the
20 lack of online social support and interaction, might mean they are at particularly high risk of
21 some of the negative social and psychological impacts discussed in this paper. Future
22 research will explore at-risk groups' experiences in depth. Future papers will also explore
23 further the similarities and differences in views and experiences in the perceptions of
24 experiences of participants living in different parts of the UK (e.g. London compared to less
25 densely populated areas), a theme only briefly discussed here due to limitations of scope.
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49 **Implications for policy and practice**

51 This study suggests that for some, the social distancing and isolation associated with COVID-
52 19 policy may have had negative impacts on mental health and wellbeing. The prevalence of
53 COVID-19-related depression and anxiety, and the extent to which it will last beyond the
54 removal or relaxation of social distancing and isolation policies remains to be seen. Our
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3 ongoing research will explore these social and psychological impacts longitudinally.
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5 Policymakers and the public health community must discuss measures to respond to the
6
7 likely wave of mental ill-health which is expected to follow, and which is tentatively
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9 suggested by our early qualitative evidence. The theme of loss and addressing public
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11 concerns around physical and emotional losses (e.g. meaning and self-worth), may inform
12
13 current and future therapeutic interventions. Loss of meaning and self-worth may be due in
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15 part to loss of control, and increasing a sense of control for the public should be considered in
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17 future policy, intervention, and programming.[23] Additionally, findings suggest that a rapid
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19 response is necessary in terms of public health programming to mitigate these mental health
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21 impacts. Waiting until restrictions and isolation measures are relaxed or removed to provide
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23 support services could potentially have devastating impacts. Government and the public
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25 health authorities should look at ways of extending mental health outreach services,
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27 especially remotely.[24] Timely attention is needed for those who are predisposed to
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29 depression and anxiety, those who may be suicidal, and those experiencing significant social,
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31 economic and personal loss.
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38 Our study also suggests that although the COVID-19 pandemic has disproportionately
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40 negatively affected those in low-paid or precarious employment. Future research and policy
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42 should therefore seek to develop measures that specifically seek to remediate the social,
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44 economic and psychological harms related to COVID-19 as experienced by those from
45
46 disadvantaged backgrounds. Looking ahead to later stages in the current pandemic, or to the
47
48 development of pandemic preparedness programmes for the future, a couple of lessons can be
49
50 distilled, which warrant urgent attention. Firstly, initial high levels of support for, and
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52 adherence to, social distancing and isolation measures are likely to wane over time,
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54 particularly where end dates are and remain uncertain. Secondly, in planning the ‘exit
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56 strategy’ for the UK lockdown, and its possible impact on future resurgences of COVID-19
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3 infection, policymakers and public health authorities need to account for the fact that,
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5 although some individuals will voluntarily or habitually continue to socially distance (graded
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7 social reintegration) others will seek immediately to re-integrate fully beyond what they are
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9 permitted to.
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58 DECLARATIONS

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17
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Standards for Reporting Qualitative Research (SQRQ) Checklist

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| S21 | Funding | 28, 29 | 56-59, 3-8 |