# Understanding Loneliness and Social Exclusion in Residential Centers for Social Inclusion

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Loneliness and social isolation are widely recognized as one of the most important and deep-rooted problems facing society, with special impact on people who are immersed in processes of social exclusion. The study examined the relationship between loneliness and social exclusion in residential centers. It used phenomenological interviews ($N = 11$) to explore the subjective experiences of loneliness among people in residential centers for social inclusion to determine the variables associated with their emergence and development, as well as the factors aggravating or alleviating the influence of loneliness on their lives. The results yielded five themes associated with the loneliness of residents, with an interweaving of different axes of exclusion: (1) loneliness and unfulfilled need for meaningful relationships; (2) family losses and conflicts; (3) the experiences of homelessness and residential centers; (4) the economic dependence, contribution, and social inclusion; and (5) the loneliness associated with marginalization and social stigma. Authors present the implications of these findings on social work and some lines of psychosocial intervention.

KEY WORDS: *exclusion; loneliness; residential centers; social isolation; social work*

The importance of addressing unwanted loneliness to improve people's psychosocial well-being is increasingly recognized at national and international levels. Those who are experiencing homelessness, especially, are a population highly susceptible to social isolation and loneliness due to the breakdown of significant relationships.

It is estimated that 21.9% of the total population at the European level is at risk of poverty and/or social exclusion (Guio et al., 2021). In the European Union, the concept of social exclusion has been used to address situations of poverty, inequality, vulnerability, and marginalization of segments of its population. The current processes of social exclusion coexist alongside traditional forms of poverty, with implications for the dimensions of social citizenship, such as the lack of quality employment and access to decent housing. To measure poverty and social exclusion, the "at risk of poverty and/or exclusion" (AROPE) indicator of the European Network for Combating Poverty and Social Exclusion is used as a reference.

According to the latest report on the risk of poverty and exclusion carried out by the Spanish branch of the European Anti-Poverty Network (EAPN-Spain), in 2020 a total of 12.5 million people, representing 26.4% of the Spanish population, were at risk of poverty and/or social exclusion. The Spanish data are above the European Union average for practically all the variables of poverty, exclusion, and inequality (Llano, 2021). Thus, the AROPE rate, the risk of poverty rate, and the percentage of households with low intensity of employment are higher than the average for all European Union countries. The AROPE rate is not homogeneous for all citizens, with important differences according to gender, age, nationality, type of home, and disability, among other variables. The risk of living in a situation of social exclusion is higher for women (27.2% compared with 25.2% for men) and migrants (43.4% for those born in the European Union and 58.1% for those from the rest of the world, compared with 22.6% of those born in Spain). By age, the AROPE rate is particularly high among young people between 16 and 29 years old (30.3%). Special mention should be made of the situation of single-parent households (mostly made up of women; 49.1%) and people with disabilities (33.8%). Currently, since the crisis produced by the COVID-19 pandemic, the exact dimension of this problem is not known, but

it is estimated that the number of people in a situation of poverty and/or exclusion will increase in the short term (Walker et al., 2020).

The European Federation of National Organisations (FEANTSA) definition of homelessness includes rooflessness, houselessness, living in insecure housing, and living in an inadequate accommodation. This four-part classification of homelessness and social exclusion attempts to cover all living situations that qualify as forms of homelessness across Europe. According to the latest FEANTSA report (Fondation Abbé Pierre & FEANTSA, 2019), being younger than 30, of foreign origin, or a single mother with dependent children are factors that increase the risk of homelessness.

The World Health Organization (2010) defines *social exclusion* as a dynamic and multidimensional process in which four dimensions interact: economic (income, employment, housing and living conditions), political (access to rights and services), social (social and family support networks), and cultural (acceptance of social values and norms). Thus, approaches to tackling exclusion combine economic and social strategies (unemployment, immigration, etc.) with interventions emphasizing the roles psychological and microsocial factors (social rejection, isolation, loneliness) play in mental health, well-being, and quality of life (Cattan et al., 2005; Heinrich & Gullone, 2006).

According to Peplau and Perlman (1982), loneliness is an unpleasant experience that occurs when a person's network of social relationships is deficient in some important sense, either qualitatively or quantitatively. As a subjective emotional experience, it is mainly affective and cognitive in character (Heinrich & Gullone, 2006). It is worth mentioning Weiss's (1973) differentiation between emotional loneliness (loss of significant social relationships with feelings of emptiness and anxiety) and social loneliness (lack of a social network—family and friends supporting and involving the person in their interests and activities—with feelings of marginality, lack of support or help, etc.).

Among those experiencing homelessness, a high prevalence of mental disorders has been found, in particular substance use disorder involving alcohol and psychoactive substances (Panadero-Herrero & Muñoz-López, 2014), as well as chronic diseases and disabilities (Roca et al., 2019). The associated stigma has been identified as a risk factor for loneliness and truncated, fragile relationships (Hawkins & Abrams, 2007).

The few studies examining loneliness among those who are experiencing homelessness show that they are particularly vulnerable to loneliness. In a survey of 506 British users of homeless services, Sanders and Brown (2015) found that 77% felt lonely sometimes or often, over twice the percentage found in mainstream communities (35.7% in the study by Lauder et al., 2004). The social networks of these people are reduced (Neale & Stevenson, 2015) due to the loss and absence of family members (Hawkins & Abrams, 2007), interpersonal issues like relationship breakdown, childhood trauma, and adverse life events (Fitzpatrick et al., 2013). The results of the study by Rokach (2005) indicate that the experience of loneliness for those who are homeless is significantly different from that of the general population. People experiencing homelessness were found to have significantly higher mean scores on emotional distress, social insufficiency, interpersonal isolation, and self-alienation, showing a greater inability to adhere to cultural dictates of social connections and social support. Among this population, men and women did not differ significantly in their experiences of loneliness. Homelessness appears to be so devastating, alienating, and stigmatizing that it affects the loneliness of men and women similarly.

Migrants are a particularly vulnerable group due to situations of administrative irregularity and fragile social contexts that increase risk (Navarro-Lashayas & Eiroa-Orosa, 2017). Marginalization in society may contribute to loneliness. Indeed, there is greater stigma toward "the homeless" than toward the poor with housing, similar to those stigmatized by mental illness (Phelan et al., 1997), and this may contribute to feelings of isolation, loneliness, and shame. This shame may in turn cause people to negatively appraise their relationships with others who are experiencing homelessness (Sanders & Brown, 2015), feeling less satisfied with their existing relationships and evaluating culturally normative relationships (Neale & Brown, 2016) involving friends, family, and providers of services more positively. The results of the qualitative study by Bower et al. (2018) with people who are experiencing homelessness show limited social networks caused by marginalization. They experienced rejection; the loss of critical network

members, including family rejection and lack of company; and poor, precarious relationships within the homeless community.

Associated with residential exclusion, empirical evidence from older people shows that the prevalence and risk of social isolation and unwanted loneliness are higher for people living in nursing homes for the elderly than for those living in private homes within the community (Prieto-Flores et al., 2011). For institutionalized individuals, the variables that most explained loneliness were not being able to get together with family, friends, and neighbors, unlike noninstitutionalized people, whose loneliness was explained by gender and marital status (Prieto-Flores et al., 2011). The results of the qualitative study by Paque et al. (2018) in nursing homes showed that residents' unfulfilled need for meaningful relationships played a crucial role in feelings of loneliness, as well as loss of self-determination due to institutionalization.

Andrew and Meeks (2018) found an important relationship between person-centered care—particularly compliance with personal care and recreation preferences—and the socioemotional needs of long-term care residents. Community programs play an important role in social inclusion, and interventions focused on social involvement and support are effective in reducing loneliness (Stojanovic et al., 2017). The quality of relationships with neighbors was also significantly associated with loneliness and sense of community in people with mental health problems (Kriegel et al., 2020). For all these reasons, social inclusion services support people in situations of exclusion through personalized attention and collaborative work with local communities to improve participation and social adaptation (Huxley et al., 2009).

The high levels of social exclusion in Europe (Guio et al., 2021) and the paucity of studies exploring how social networks, isolation, and loneliness are experienced among people in situations of residential exclusion (Bower et al., 2018; Paque et al., 2018) justify the present research. There is an emergence of programs and services specifically aimed at addressing homelessness in Spain. Residential centers for social inclusion are designed for individuals with serious personal, social, and relational impairments in situations of exclusion. These centers provide accommodation with medium- or high-intensity support services aimed at promoting social inclusion. The network of social inclusion services and programs is the responsibility of the Provincial Council of Gipuzkoa. The network is made up of residential centers in which the stay is conditional on compliance with a socioeducational program, professional assessment of the case, and compliance with an individual care plan. The residential centers for social inclusion prevent homelessness by providing safe and affordable supported housing in a communal setting. They provide accommodation, meals, care, and supervision based on individual needs. These centers are not considered to be the primary residence or dwelling of the persons receiving care.

The main objective was to analyze the subjective experiences of loneliness among people in residential centers for social inclusion and to determine the variables associated with their emergence and development, as well as the factors aggravating or alleviating the influence of loneliness on their lives. Among other aspects, we explored the intersection of loneliness with social variables such as socioeconomic and residential inequality, gender, the situation of migrants, and physical or mental health problems. This study aimed to answer two key questions: (1) What is the experience of loneliness among socially excluded people? (2) To what extent are these experiences related to different axes of exclusion? This analytical approach represents a novel contribution in the Spanish context, as international studies on the loneliness of people in situations of exclusion are scarce, most of them being quantitative and focusing on old age, widowhood, and one-person households.

## METHOD

Our research is qualitative with a phenomenological approach (Schutz, 1967), using in-depth interviewing with an open-ended question guide to ensure focused and detailed data collection. Phenomenology is a qualitative process that allows the researcher insight into the rich experience of a group of individuals through the perspective of people who have lived that phenomenon. This method allows researchers to explore the meaning, structure, and essence of the phenomenon and search for the underlying meaning from its protagonists (Creswell, 1998). To get to the heart of the experience of loneliness in this study, data were collected mainly through qualitative interviews. The information was supplemented by objective

data from the social diagnosis based on the Instrument to Assess Social Exclusion of the Basque Social Services System.

The interviews were focused on the participants' experiences of loneliness. We asked questions such as "What does loneliness mean to you?" and "Could you tell me about your loneliness?" The interview process started with a general overview of the loneliness experience, and over the course of the interview, the interviewees were gradually asked to speak freely about their loneliness associated with the following topics: economic and employment situation, accommodation and housing, mental and physical health, social skills and competences, affective bonds, and social support. The interviewer had a guide with questions, which was adjusted to the interviewee. Standard questions were used. For example, in relation to the economic and labor situation, the interviewer asked: "Please tell me about your experience of loneliness in relation to your economic and labor situation. How has your economic and labor situation affected your relationships and your experience of loneliness? Has it always been like this, or has it changed over time?"

## Participants

Eleven people (five women and six men) living in five social care centers managed by the Provincial Council of Gipuzkoa participated in this study. The types of centers included residential centers for people in a situation of chronic personal and social deterioration ($n = 2$), residential centers for social inclusion ($n = 2$), residential centers for female victims of domestic abuse and other residential services for women ($n = 3$), night shelters ($n = 2$), and an inclusion program for people in situations of social exclusion with residential coverage ($n = 2$). A description of the different types of residential centers is presented in Table 1. Some participants have experienced different types of homelessness over time. The history of homelessness ranged from weeks to 10 years. Of the 11 participants, four had ever been homeless.

Ages of participants ranged from 22 to 60 years ($M = 43.27$). Seven were born in Spain (native) and four were of Moroccan origin (migrant). The 11 participants were without a partner (five were single and six were separated or divorced), and six had children. Regarding their health status, eight participants had a mental illness diagnosis (i.e., major depressive disorder, schizoaffective disorder, borderline personality disorder), and seven had some type of physical illness and/or disability (i.e., HIV, heart disease, functional deviation of the spine, osteoarthritis). All of them showed high levels of loneliness (scoring >6 points out of 9) on the UCLA Loneliness Scale (Hughes et al., 2004). The data corresponding to the social diagnosis of the participants can be found in Table 2. This information was gathered through the Social Exclusion Assessment Instrument of the Basque Social Services System (used by the Provincial Council of Gipuzkoa, Decree 385/2013).

## Procedure

The sample was selected in Gipuzkoa (Basque Country), a region with a long history in social policy and social services. A convenience sample was used, with an intentional search for participants to guarantee the saturation and richness of the information. The criteria for inclusion in the study were (a) high levels of loneliness, (b) risk of or in a situation of social exclusion, and (c) willingness to participate in the study. Participants were selected by professionals from various collaborating residential institutions for social inclusion who explained the study and its objectives, then requested collaboration. The professionals in the collaborating social entities were in charge of all data collection regarding the inclusion criteria (high levels of loneliness and social diagnosis), through the UCLA scale and the Social Exclusion Assessment Instrument of the Basque Social Services System, respectively. This information was collected before the interviews were conducted.

The individuals were invited to meet with the researchers to determine a convenient time and place for the interview. Of the 14 people invited, 11 agreed to participate. Anonymity, voluntary participation, and confidentiality were ensured, and procedures adhered to institutional, national, and international ethical guidelines. Information about the study and informed consent was read aloud and clearly worded to assist participants with literacy problems. Recruitment ceased when data saturation was reached and few new understandings of loneliness were identified in subsequent interviews. Guest et al.'s (2006) research showed that saturation tends to occur within 12 interviews.

The interviews took into account the influence that the nature of the relationship between

**Table 1: Description of the Residential Centers for Social Inclusion**

| Term | Definition |
|---|---|
| Residential center for people in a situation of chronic personal and social deterioration | Center for people in a chronic situation of deterioration who require a long-term care with an approach that combines social inclusion with a slow pace of intervention |
| Residential center for social inclusion | Center aimed at facilitating the social inclusion of people with severe psychosocial deprivation and/or the transition to stable housing for people experiencing homelessness who require high-intensity psychosocial support |
| Residential center for women dealing with domestic abuse and other issues | This would include immediate reception centers, half-stay centers, and sociolegal and psychosocial care service for those who were victimized, suffering sexual abuse or violence |
| Night shelter | Facility aimed at people in a situation of social exclusion who require a place to spend the night and have their basic needs covered |
| Inclusion program for people in situations of social exclusion, with residential coverage | A temporary reception program to carry out an assessment or diagnosis that allows the most appropriate individualized care plan to be initiated or followed |

**Table 2: Social Diagnosis: Situation of Vulnerability or Deficit in Different Areas**

| Characteristic | *n* |
|---|---|
| Economic—work environment | |
| Income | 8 |
| Occupation, employment | 8 |
| Relationships—community | |
| Relationships and affective bonds | 11 |
| Social support of primary networks | 11 |
| Social support of secondary and community networks | 8 |
| Personal | |
| Interaction skills | 6 |
| Cognitive competences | 5 |
| Friendship skills | 8 |
| Coexistence skills | 6 |
| Health | |
| Mood | 9 |
| Health condition | 9 |

participant and interviewer has on data collection. For this reason, the principles of qualitative interviewing (Carr, 2011) were considered. The interviews were carried out in the residential centers in the summer of 2019 in a quiet room that the interviewee was familiar with. The interviewer was a female researcher trained in clinical psychology. She was not an employee of the residential center and had no previous relationship with the participants. These conditions have facilitated a relationship of trust, acceptance, respect, and relative security. Therefore, the interviewee could not obtain any benefit from conducting the interview, which makes the responses unconditioned. The interview sessions lasted between 60 and 150 minutes and were recorded and transcribed by two members of the research team verbatim, including annotations of nonverbal expressions such as silence, laughter, and crying.

## Data Analysis

We used the method of thematic analysis, which allows the researcher to identify, organize, analyze in detail, and report patterns or themes from a careful reading and rereading of the information collected to infer results that promote adequate understanding and interpretation of the phenomenon under study (Braun & Clarke, 2006). For further insight, each interview was listened to again after transcription. A third team member listened to the recordings and reviewed the transcripts. These three researchers performed their analyses separately. An initial list of emerging themes associated with the loneliness experiences of people in exclusion processes was drawn up. These were then assigned to larger categories of themes and subtopics based on similarity and overlap and subsequently refined and revised based on the original transcripts. Finally, the emerging themes were classified through inter-rater agreement, which made it possible to work with a highly reliable classification system. The trustworthiness of the study findings was enhanced by applying the Lincoln and Guba

(1985) criteria: credibility, transferability, dependability, and confirmability. These criteria were met through purposive sampling review of interviews by professionals in residential centers for social inclusion, and experts in qualitative research were used to ensure peer debriefing. Potentially identifying information was removed from transcripts, and pseudonyms were assigned to participants.

## FINDINGS

The interviews yielded five themes associated with loneliness. The first theme explored the meanings of loneliness and unfulfilled need for meaningful relationships. The second topic analyzed family losses and conflicts in the experience of loneliness. The third focused on the street situation, residential centers, and their impact on loneliness. The fourth was centered around dependency, and social contribution and inclusion. The fifth dealt with loneliness associated with stigma and social rejection.

### Meaning of Loneliness and the Unfulfilled Need for Meaningful Relationships

The interviewees recognized the differences between the subjective perception of loneliness and their objective experience. They explained clearly how, despite objectively having contact with different people, the subjective experience of loneliness persists and becomes a chronic experience. It is this subjectivity that makes a person find themselves surrounded by a crowd and yet feel deeply alone.

> I've always felt lonely, everywhere I've been, even having people around me. . . . It's not about being physically alone . . . it's a loneliness inside. Having people around helps, but that loneliness is always there, it's a constant. (Carlos, 53 years old)

The absence of networks and the lack of company when they need it, experienced as a feeling of emptiness, nostalgia, sadness, anguish, and despair, is salient. Participants specifically referred to emotional loneliness, to the absence of attachment relationships, that is, the lack of relationships that are especially significant for the person.

> Being alone without support from anyone, without support and without contact with anyone. Without physical contact, or speaking, or anything, loneliness is an emptiness. (Leyre, 46 years old)

The search for company, friends, partner, or significant relationships with whom to pass the time and share daily life was expressed by the participants in terms of longing and nostalgia. This need is activated by memories of the past when loneliness did not exist, when significant dates or social rituals are recalled in which social sharing has a symbolic value that works as a mirror of loneliness.

> To be honest, I've sometimes resented the fact that I'm alone during celebrations like Christmas and things, that I don't see anyone. (Amaia, 40 years old)

Participants referred to different maladaptive coping strategies that, in their words, point to ways of "covering it up" or "filling the void." Some reported uncontrolled consumption of food, alcohol, or other drugs, as well as those who claim to engage easily in toxic relationships just by being with someone, or those who lose control of money management.

> It often leads me to hurting myself. To drink until I drop, take speed . . . especially to drink. That's the worst thing for me, I'm always escaping, doing things to the max to forget about that loneliness and that emptiness. (Carlos, 53 years old)

### Losses and Family Conflicts in the Experience of Loneliness

Several of the interviewees mentioned that they had been exposed to situations of abandonment by some of their attachment figures from an early age.

> I've always had that inside, ever since I was little. I remember when I was three, holding on to the balcony railing alone with no one by my side, abandoned. I don't remember my mother until I was 14. I had no relatives. I knew my neighbor better than her. My mother has never given me anything. . . . When she's around, it's as a figure of punishment, not of help. (Carlos, 53 years old)

Also, family conflicts or problems of family life (sometimes with convictions or restraining orders) have a direct impact on intensifying feelings of loneliness. For some, a breakdown in a relationship precipitated homelessness, a factor that has been identified as central to exclusion and the experience of loneliness.

> I left home when I had a pretty heated argument and now, I have a restraining order. I feel sad, I don't even want to think about it, I get them out of my head, but the problem is there, the problem is in my mother and my brother. (Leyre, 46 years old)

A recurring element in interviews is life as a couple and separation or divorce, which is experienced as a key life situation related to the feeling of loneliness.

> I have been admitted to psychiatric centers for depression, the first time when I was 23. Lots of suffering. The boyfriend of a lifetime . . . Eight years together and it ended, and for me it was a very hard blow that affected me too much. (Isabel, 57 years old)

In other cases, separation or divorce has led participants to distance themselves from their children and from their previous lives, thus losing self-control and falling into drug and alcohol use.

> I have a daughter, but she doesn't want anything to do with me. She wrote me a letter saying that it was hard to have been left without a father, it was as a result of separating and getting hooked on drugs. By separating, all I did was throw away everything I had done. (Alfonso, 60 years old)

Talking about loneliness is also a way of connecting with all those experiences that are part of a painful life journey or trajectory, situations of gender violence, either as a result of having been exposed to it in childhood or having suffered it from a partner or some relative.

> It's like I've also had loneliness forced on me. Well, before I came here, I was abused by one of my brothers, and I felt destroyed by him, that's why I'm here, because I had no other place to go other than my parents' house, and that was his house. (Isabel, 57 years old)

Deaths of parents or close family and friends were reported to exacerbate feelings of grief and loneliness.

> There are people who aren't around anymore. People who I was close to who died and of course, that's already impossible, like my mother, for example. (Isabel, 57 years old)

In the stories of those who had arrived from abroad, loneliness is explained through mourning and uprooting with respect to the place of origin and family, especially in those who migrated as minors:

> Loneliness is a very hard thing, I suffer a lot from that, from loneliness and emptiness. Everything is more difficult being alone. Away from your family you are alone . . . being alone is when you need something and you don't get it, you need your mother's love and it isn't there, to be with your father and you can't. (Ahmed, 25 years old)

### Homelessness, Residential Centers, and Their Impact on Loneliness

Another element associated with loneliness is related to residential exclusion and homelessness. The struggle for self-survival hinders the fabric of trustworthy social relationships, especially in women who suffer situations of sexual objectification or the demand for sexual favors in exchange for support.

> There are a lot of wild people on the street. The street is like that because nobody cares about anyone else . . . because it's a toxic situation. When you're on the street there's always someone to help you, but then they want something in return, and if you're a girl, it's worse. (Shara, 26 years old)

However, at the same time, there are also links of support and mutual help between people in the same situation.

> I met a man who knew all this about the street and helped me a lot. He lives in Almería and I still talk to him. He taught me in part what the street really was, which is very painful, very hard and painful. (Amaia, 40 years old)

These situations are also repeated in residential centers for social inclusion, where the type of accommodation also affects the social relationships that are established. Most of the participants were clear that living in the center meant a significant loss of autonomy. The rules to be followed in residential care, which usually have to do with schedules, economic administration, substance use, etc., are often perceived as limitations for connecting with other people or as loss of autonomy and intimacy.

> In the center there are schedules, there are tasks to be respected, many things to do, it's not like being at home, you can't do whatever you want. If lunchtime is half past one and you arrive at two, there's no food left for you. If you don't respect the rules of the center, they can kick you out. (Hasîm, 39 years old)

Living with the other residents often becomes a source of conflict, either due to their different profiles or life trajectories, which get in the way of connections and relationships between them. Thus, some people explicitly say that they do not want to be intimate with their peers. They are reduced, fundamentally, to relationships of respect and coexistence.

> With the others here, we all respect each other, and I respect them, sometimes we talk a little about everything, but not about each other's personal life. Just things like that to hang out, and then everyone goes to their room. (Hasîm, 39 years old)

Despite this, some people recognize that residents and staff are the only figures of support for them, to help them feel respected, listened to, and even loved.

> Now I have the support of a man, we support each other, we give each other advice. He is the only person I trust. And the social and mental health worker, both of them. I'm pleased with them, and now they have assigned me a psychologist, too. It always strikes me how calm they are here, supporting you to follow the path, they support you, they are with you. They don't leave you alone. (Leyre, 46 years old)

Participants pointed out as positive the fact of having their basic needs covered, the individualized treatment given to them, as well as stability and support to carry out a process and achieve the proposed objectives.

> You have a stable thing, you're not in one shelter one day and in another shelter the next. You are working on a process to reach the goals you want. I'd like to find a job and follow my classes that I am doing here, and to save and leave with a decent life. Economically, they have helped me a lot, people from social services and people from centers. (Shara, 26 years old)

### Dependence, Contribution, and Social Inclusion

The interviewees who were receiving some type of financial help indicated that they feel ashamed about receiving these handouts, even though they are aware that they have a social right to them.

> I would have liked, like many people, to pay for my own retirement, but due to my life situation it wasn't possible. I am a fighter, but as I wasn't able to have another lifestyle, then of course this financial support is welcome. I can no longer work, I'm no longer needed anywhere. If I could work, I would work. (Isabel, 57 years old)

The social benefits cover basic costs such as food or clothing; however, they are not sufficient to cover expenses such as renting a home or even a room in a shared apartment. These economic difficulties are an impediment when moving out or doing leisure activities that would have been helpful in increasing social contact and alleviating feelings of loneliness.

> I have just enough to live on. I don't have a social life during the week other than just going for a coffee. I can't afford to go out for dinner or go to the cinema. The idea of leisure activities gets to you because obviously you can't be going out and spending €20 whenever you want. I haven't been out with friends for years because I just can't afford to. (Amaia, 40 years old)

In addition, those who work or carry out some volunteer activity say they feel more useful, more fulfilled and socially integrated. This social contribution relieves feelings of loneliness and allows them to escape from their daily worries.

> I go to the greenhouse in the morning as a volunteer. It makes me feel very good, useful. Doing activities helps me to reduce feelings of loneliness. (Carlos, 53 years old)

The temporary nature of the center and the help it provides featured repeatedly in the course of the interviews, highlighting that interviewees do not want to become too comfortable there since the facility is understood as a tool that can provide them with the impetus to improve their current situation.

> I need more money, I need to work, because I don't want to stay here. . . . There are people I know who stay at a center, going from center to center. I think that a center is for those who need it at that moment, to give a push for that moment, but not to stay there indefinitely. (Leyre, 46 years old)

### Loneliness, Stigma, and Social Rejection

The testimonies of the participants show family rejection, the stigma associated with their economic situation, as well as that caused by other aspects linked to their status as migrant or having mental health problems. Some participants experienced rejection from their family when they did not meet their expectations.

> My family believe that I do everything wrong. It wouldn't matter to them if I died. They would breathe a sigh of relief. That causes me pain, anger, abandonment, hopelessness. They only call me when I'm sick. They have hurt me a lot. It makes me feel very angry, helpless. They only care about themselves. (Carlos, 53 years old)

In addition, the interviews show how receiving benefits or living in residential centers for social inclusion made people feel shame caused by stigmatization and the social rejection of these social realities.

> In my second medical examination review they raised the percentage of my disability. So it means that I'm not well, that I've gotten worse. On the one hand, I am ashamed to say that I get this help. I would like to earn it by myself and not have to go through what I'm going through. Handouts will not cure what I have. (María, 51 years old)

Economic difficulties not only limit their opportunities to interact with other people, but are also a reason for exclusion and rejection in their social circles.

> Some friends are only interested in money. My brothers and sisters, when I was doing well, they came every day and they took advantage of me, and when I was bad, that's when they leave you out. (Javier, 57 years old)

Immigration status also affects the social relationships. There are barriers on the part of the native population to relate to those who are not. Sometimes these participants receive explicit racist insults and/or are forced to explain when there are cultural and religious differences.

> It's a little difficult to talk to people here, they make you feel bad, like … I'm a Moor. It's sad. Only those from Cáritas [social center] are friends, but no one else. There are other people from my country here, with the Spaniards in class, but not outside of class. I don't know where the problem is. (Said, 22 years old)

People with mental illness also reported how, through these situations, they are socially stigmatized and rejected.

> People hear that you're taking medication and say, "This woman is crazy," things like that, but the reality is something else. (Shara, 26 years old)

## DISCUSSION

Although some research has been carried out on social predictors and the impact of loneliness among people experiencing homelessness, studies investigating these experiences from the perspective of those involved are scarce (Bower et al., 2018). For this reason, our study explored how people in situations of exclusion in residential centers for social inclusion understand their loneliness and the factors associated with it. The life trajectories studied make it possible to give visibility to the experiences of their protagonists, whose subjective reality and agency is not often reflected and therefore possibly not adequately addressed.

The interviews explored the meanings of loneliness, fundamentally associated with the perceived quality of relationships and unfulfilled need for meaningful relationships. Residents described the absence of networks and the lack of company when they needed it, experienced as a feeling of emptiness, nostalgia, sadness, anguish, and despair. Relationships with significant others that did not meet their expectations increased their sense of loneliness, consistent with the definition of Peplau and Perlman (1982), and the findings of other research (Paque et al., 2018) on the association between emotional loneliness and residents' expectations regarding relationships with family and friends.

The absence of family due to abandonment, loss, conflicts in living together, separations, or other causes (e.g., sexual abuse, exposure to gender violence) emerges as a second relevant issue in the experience of loneliness. These results are consistent with research showing that the social networks of homeless people are small and fragmented due to the loss and absence of childhood family members (Hawkins & Abrams, 2007), the breakdown of significant relationships, childhood trauma, and adverse life events (Fitzpatrick et al., 2013).

The third theme focused on the experiences of living on the street and in residential centers. Homelessness hinders the developed of social relationships of trust and affects the ability of the participants to weave social relationships. However, some participants report that new friendships developed in the street network that can mitigate and calm the deep feeling of loneliness experienced on becoming homeless. While housing in residential centers provides some degree of social contact and support from other residents and professionals, the relationships that are established often lack longevity and depth and do not appear to be sufficient or to satisfy residents' need for meaningful relationships. Moreover, loneliness was strongly associated with the loss of autonomy and intimacy due to institutionalization, as found in other qualitative research with institutionalized older people (Paque et al., 2018). According to the results of a qualitative study identifying autonomy or self-determination and significant (individualized) activities as central dimensions of residents' quality of life (Schenk et al., 2013), participants in our study also particularly valued individualized attention and meaningful relationships with professionals.

The fourth theme focused on loneliness associated with the situation of economic dependency, contribution, and social inclusion. Socioeconomic difficulties and dependence on social aid are experienced as reasons for shame and social exclusion. Having financial resources can increase people's opportunities to participate in a greater variety of activities that counteract loneliness (Hawkley et al., 2008), which favors the feelings of social utility and inclusion.

A fifth theme associated loneliness with marginalization and stigma in the participants' social experiences. They reported experiencing rejection from family and other close relationships, the stigma associated with their economic situation and homelessness, as well as that derived from other identities linked to their migrant or mental health status. This rejection negatively affected their perception of themselves, existing relationships, and their ability to form new relationships.

Participant testimonies often alluded to the desire for culturally normative relationships with their families, friends, or new relationships could can establish in work, training, or leisure spaces. However, the reality is that participants tend to interact with other marginalized people, whose relationships, despite providing social capital by offering company and security, were considered less valuable. This finding is reflected in other studies that determined residents wanted culturally normative relationships (Neale & Brown, 2016)

and that homeless people spend less time with people they want to contact (usually friends and family) and more time with networks of people in situations of exclusion (Sanders & Brown, 2015).

The themes emerging from the interviews are consistent with the greatest deficits detected in the social diagnosis made from the files, related to occupation and employment, as well as personal relationships and family coexistence, of relationships with the extended family, and the social support of secondary and community networks. The greatest strengths are found in the personal sphere: half of the participants exhibited adequate basic cognitive competences and an adequate level of basic interaction and communication skills.

From a multilevel perspective, some intervention proposals are presented, based on the findings of the study. At the individual level, it seems important to sit with and to listen to the residents, attend to their preferences (Andrew & Meeks, 2018), and see what the barriers and difficulties in combating loneliness are in order to build possible solutions with them (Paque et al., 2018).

At the group–relational level, it is essential to promote meaningful relationships and social networks that allow social contact thanks to the sustainability and support that connection with people can offer (Stojanovic et al., 2017). It seems relevant to facilitate contact scenarios and the organization of group activities to help generate social networks. It is vital that healthcare professionals pay attention to resident preferences, favoring the promotion of meaningful relationships with members of the community (Neale & Brown, 2016).

One of the key issues on the social–community level, highlighted by residents as the main difficulty, is centered on social stigma or rejection due to their condition as people in situations of exclusion, migrant status, or having mental health problems. In this sense, it seems important to promote spaces of interaction based on values of commitment to mutuality. This consists of involving society in various initiatives in our daily life through activities with groups of volunteers and neighborhoods (Kriegel et al., 2020) to reduce the social stigma and rejection toward people in situations of exclusion, generating social networks with people from the general population. It should be noted that social prescribing enables practitioners to signpost service users to a range of nonclinical community activities (South et al., 2008). Social prescribing schemes can involve a variety of activities, which are typically provided by voluntary and community sector organizations. Examples include volunteering, arts activities, group learning, gardening, socializing, cookery, healthy eating workshops, and a range of sports. Activity participation is increasingly promoted as an approach to address loneliness, social isolation, and other psychosocial issues (Holding et al., 2020), and there is evidence that social prescribing can have a positive impact on the health and well-being of service users (Bickerdike et al., 2017).

A psychosocial approach must not overlook intervention at the macro level. Until now, employment has been the main way to access the most basic material needs and to provide a space for social relationships and belonging. In this regard, guaranteed employment policies might be necessary. However, in a historical context where the market is unable to offer such guarantees for a significant social majority (Srnicek & Williams, 2017), public policies must be deepened to ensure decent living conditions beyond integration in the workforce (e.g., Unconditional Basic Income; Standing, 2018).

Thus, it seems key to enable a psychosocial approach to loneliness, which involves making an early detection of the processes of isolation and exclusion, considering that there are some precipitating life situations (family losses and conflicts, mental health problems, immigration, economic and job insecurity, etc.) that exacerbate these processes. We should also promote public policies related to employment and economic benefits that are understood as a right and not as social shame, as well as raising awareness to reduce stigma and social rejection toward people at risk or in situations of exclusion.

The most obvious limitation is the small sample size of the study. Nevertheless, the analysis of the interviews highlights the most relevant aspects of the experiences of loneliness and living in a situation of exclusion, consistent with Finlay and Kobayashi (2018), who underline the contribution of the qualitative approach in the study of loneliness for giving meaning to categories that cannot be grasped through quantitative research. Although research shows that saturation tends to occur within the first dozen interviews (Guest et al., 2006), with regard to new studies, it would be interesting to look for other profiles to ensure a broad

representation of people in residential centers for social inclusion (young people, older people, male victims of violence, people with different gender identities, etc.), thus guaranteeing diversity of the information obtained. Finally, despite the participants having been selected by professionals based on scientific criteria and knowing that they would provide quality information, the methods of this study do not allow for the detection of social desirability bias. SWR

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