Perceptions of loneliness among people accessing treatment for substance use disorders

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© 2020 Australasian Professional Society on Alcohol and other Drugs Introduction and Aims: Guided by cognitive theory of loneliness, this study sought to explore the experience of loneliness among people accessing treatment for substance use disorders. Specifically, contributors to, consequences and alleviators of loneliness were explored. Design and Methods: Individual semi-structured interviews were conducted with 20 participants. Interviews were conducted onsite at two residential treatment facilities in New South Wales, Australia. Interviews were audio recorded and transcribed and an iterative categorisation approach was used to guide data analysis and reporting. Results: Four key themes emerged as contributors to and consequences of loneliness: cognitions (mistrust, perceived support from others, low self-worth and fear of negative evaluation), quality and authenticity of relationships, unhelpful interpersonal behaviours and the role of substance use. Participants indicated that overcoming the cognitive and behavioural perpetuators helped to alleviate loneliness and also described the utility of support groups, pursuit of authentic relationships and activities that provide a sense of purpose as helpful. Discussion and Conclusions: Cognitions related to mistrust, lack of perceived support, low self-worth, fear of negative evaluation and identification and pursuit of meaningful relationships supportive of recovery should be key treatment targets for this population.

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Discussion and Conclusions: Cognitions related to mistrust, lack of perceived support, low self-worth, fear of negative evaluation, and identification and pursuit of meaningful relationships supportive of recovery should be key treatment targets for this population.

Key Words: loneliness, isolation, substance dependence, addiction recovery, qualitative study
Perceptions of loneliness amongst people accessing treatment for substance use disorders

“Loneliness is heart breaking; you know what I mean. Like, everyone wants to be connected.” – Male (John)

Loneliness is a distressing emotion that is a universal human experience (1, 2). Loneliness is defined as a subjective, emotional state, that arises due to a discrepancy between the social connections one perceives they have, and those they desire (3). In this way, loneliness is thought to drive an individual to seek connectedness with others (4). While related to other social constructs such as social isolation, loneliness is distinct due to its subjective, emotive nature, while isolation refers to an objective lack of the quantity of one’s social relationships (5). Loneliness has been deemed a public health issue and predictor of morbidity and mortality (6) akin to smoking, obesity and physical inactivity (7). Two studies have found that loneliness is highly prevalent and problematic for people accessing treatment for substance use disorders (SUD). These studies reported prevalence rates to range from 35% (8) to 79% (9), with 69% reporting this to be a serious concern for them (9). Harmful substance use is linked to poorer physical and mental health (10), and negative social consequences such as relationship distress and emotional burden (11). This makes people with SUD highly susceptible to the experience, and effects of, disconnection and loneliness. This is likely to be due to their changing lifestyle and interpersonal needs as they move from addiction through recovery. Recovery refers to the experience of one managing their addiction and moving towards a more meaningful life (12). When in recovery, treatment providers often encourage individuals to move away from substance using groups, and towards non-using groups (13). However, people in recovery often lack supportive non-using groups due to negative social consequences of their substance use such as discrimination (14). In addition, people with SUDs have often experienced high rates of trauma, which in
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turn can enhance one’s propensity to problems with interpersonal relationships and affect management (15). These experiences, in addition to the high rates of stigma experienced by people with SUD, place them at risk of social isolation (16-18).

The limited research that has been conducted in this field has found that loneliness and problematic substance use tend to be related (e.g. 19, 20, 21), yet the nature of this relationship remains unclear. It is likely that the relationship between loneliness and substance use is reciprocal, in that substance use may provide temporary relief from the sequelae of loneliness such as negative affect or boredom (e.g. 19). For example, when feeling lonely, individuals may engage in substance use as a means of affect management, or a means of socialising and gaining acceptance from other substance users. While for others, interpersonal conflict that arises due to addiction might decrease connectedness with some groups and create isolation and loneliness. Accordingly, it is those who use substances to a problematic extent that may be more prone to loneliness (22). The broader literature has called for loneliness to be explored qualitatively due to the subjective and emotive nature of the experience (23, 24). Just two articles explore loneliness experiences qualitatively across people with SUD. The first found that participants accessing residential SUD treatment services in England experienced social distancing, loneliness and isolation (25). The second also found that loneliness was common amongst women attending Narcotics Anonymous groups in Israel and the participants reported having used narcotics as a means of escaping feelings of loneliness (19). Relationships are considered central to treatment retention and recovery outcomes (26, 27). Given loneliness and interpersonal relationships are largely intertwined, a better understanding of why this population are so vulnerable to loneliness and what appears to help to alleviate loneliness warrants further attention.

Established theories of loneliness are yet to be applied in the field of SUD. Cognitive theories of loneliness are those that propose the way an individual perceives their social
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environment will be largely influential in determining loneliness (rather than the objective state of their social environment) (28). While cognitive theories comprise a range of more specific approaches to understanding loneliness (such as Attribution theory), broadly the focus of all cognitive theories in understanding loneliness, lies in an individual’s thoughts about their interpersonal interactions, their false attributions, and dysfunctional beliefs about self and others (29). The majority of research into cognitive theories rests in the work of Louise Hawkley and John Cacioppo (30) who developed a social cognition model of loneliness. This model suggests that lonely individuals have a hypervigilance for social threat, negative expectations of relationships, and unhelpful biases to social cues. Such cognitions ultimately lead to withdrawal from others, avoidance of social contact and sabotage of social relationships, which in turn maintains feelings of loneliness (30, 31). Reviews of intervention studies suggest that targeting cognitions is likely to be most efficacious in reducing loneliness (see 24, 32) but the specific cognitions to target in such interventions are less well understood for addiction populations. Given there has been little qualitative exploration of loneliness amongst people with SUD despite it being widespread and problematic (9), the current study will contribute to the existing literature on this topic. The current study was guided by cognitive theories of loneliness and aimed to explore and describe participants’ perceptions of:

1. contributors to loneliness and in particular the role of cognitions and substance use as contributors;
2. outcomes and consequences, of loneliness; and
3. factors that help to alleviate loneliness.

Methods

Study population
The participants were 20 residents of two residential SUD treatment services in New South Wales, Australia. Eighteen (90%) participants were male and ages ranged from 20 to 63 years ($M = 37.96$, $SD = 12.05$). At the time of the interview, on average participants had been attending the service for 13 weeks ($SD = 7.27$, range 2-28) and participants reported having experienced problems with drugs and/or alcohol for an average of 14.82 years ($SD = 9.28$, range 1-40). Methamphetamine was identified as the primary drug of concern for 65% of the sample, followed by alcohol (23%), cocaine (6%) and heroin (6%). Fourteen participants (70%) agreed with the statement “I often feel very lonely”, while 5 participants (25%) disagreed, and one participant neither agreed nor disagreed.

**Study procedure**

This study was part of a larger mixed-methods research project that examined the feasibility of a group-based loneliness intervention for people accessing treatment for addiction. The study was approved by the Human Research Ethics Committee (HREC) at the University of Wollongong, NSW, Australia (HE2018/543). A researcher (II) attended the treatment centres and gave a presentation to 134 residents of the centres. Twenty-three residents expressed interest in participating in the interviews via completion of a brief Expression of Interest (EOI) form. Details about the study aims and protocol were provided to all participants prior to them providing written informed consent to take part in the interviews. Financial incentive for participation was not provided. There were no specific selection criteria, as we wished to hear from a broad range of participants about their experience of loneliness and interpersonal relationships. Participants who were interested in being involved in the study indicated how often they felt lonely using a single item loneliness measure on the EOI form, along with basic demographic variables.

An a priori sample size of 20 was selected based on the study aim, sample specificity, use of established theory and desired level of depth for the research questions to enable
meaningful analysis (33, 34). No new themes or subthemes emerged by the 20th transcript, indicating saturation was reached. All interviews were conducted on-site. Interviews were conducted between May and June 2019 and lasted for approximately 30 minutes per participant. Interviews were semi-structured and specific prompts from the interview guide were only used as necessary in order to avoid imposing themes on participants (see Supplementary material for Interview guide). Interview questions were informed by our review of loneliness literature in the field (35). Interviews began with a broad exploration of feelings and experiences of loneliness, and where necessary, participants were then prompted to reflect on experiences of loneliness and patterns of substance use. Loneliness was not defined by the interviewer, rather, participants were prompted to describe their subjective experience of loneliness. Interview questions also focused on any changes to feelings of loneliness from the period of active addiction, through to recovery, and perceptions of how the treatment service might impact on feelings of loneliness. In order to further explore cognitive theories of loneliness, participants were prompted to reflect on the types of thoughts they have when they feel lonely, and to consider what helps them to alleviate feelings of loneliness.

Data analysis

All interviews were audio recorded and professionally transcribed using a confidential transcription service. Data coding and analyses were guided by iterative categorisation (IC) (36). IC is a systematic and rigorous technique developed for analysing qualitative data within the field of addiction. IC is compatible with common analytical approaches (e.g. thematic analysis) and offers a clear, standardised guide for coding which allows for replication and validity in qualitative data analysis (see 36 for further information). The interviewer (II) read the transcripts and deduced codes based on relevance to the interview questions. Deduced codes were then supplemented by more inductive codes that emerged...
from the data, in order to facilitate more insight into the topic. Codes were then read line-by-line to identify recurring sub-themes. A member checking process, whereby participants are asked to provide feedback about the results of the study, was not used due to feasibility issues of re-contacting participants, some of whom had exited the treatment centre.

Statement of Reflexivity

The interviewer was a female PhD student with prior experience of conducting interviews and focus groups within SUD treatment services. At the time of the interviews, the interviewer was employed as a child and family psychologist, and worked and resided in a different locale to both SUD treatment services. Prior to study commencement, the interviewer did not have an established relationship with any participants of the study. The interviewer had experience conducting research at these sites, and therefore was familiar with the treatment services operations, yet was not involved in patient care.

Results

Most participants indicated current feelings of loneliness at the time of the interviews. While some participants indicated they were not currently lonely, they spoke at length about their previous experiences. Four key themes were identified: unhelpful cognitions that perpetuate loneliness (mistrust, perceived lack of support, low self-worth, and fear of negative evaluation), quality and authenticity of relationships, unhelpful interpersonal behaviours, and the role of loneliness in substance use. These themes are reported below in relation to the key research questions (see Table 1).

Insert Table 1 about here.

Contributors to loneliness

Participants described a range of things that they believed contributed to their loneliness. Cognitions about oneself and others were most prominent and appeared to be factors that were attributed to ongoing feelings of loneliness.
Cognitions.

Many participants reported a general tendency to “over-think” which they believed related to loneliness. Reports of “getting into my head” and “doing head miles” were common and were discussed in relation to difficulty trusting others, a perceived lack of support from others, fear of negative evaluation and low self-worth. Participants reported that their worry about trust often meant that they withdrew from social relationships or avoided relationships out of fear of having their trust broken again. Such withdrawal or isolation was reported to lead to, or maintain, feelings of loneliness. While not specifically citing cognitions, some participants spoke about “emotional blocks”, “boundaries” or “walls” that they intentionally and unintentionally put up.

“Yeah, it takes a while before I can fully trust someone, because, yeah, I don’t even trust my family and that, yeah, so I built, you know, like a wall” – Male (Henry)

All participants appeared to recognise the function of these “boundaries” as being self-protective and as forming out of a desire not to be emotionally hurt by others. Both females in this sample spoke at length about the impact of their mistrust beliefs on their subsequent behaviours in relationships.

“I think you — I’ve made myself feel lonely because of the trust issues I have with people. So, I pushed myself away even further. Like, I’ve been asked — had the question put to me, why don’t you want to — why can’t — why won’t you let anyone love you?” - Female (Elise)

Thoughts that no-one cares, and no-one is available for support were reported by a number of participants. Participants described a tendency not to seek out help when needed, and also to engage in substance use, due to these thoughts.
“I was lonely, and I was surrounded by heaps of people, but if I had one person there that cared about me and knew, I wouldn’t have felt lonely…. If no-one cares about me, I might as well just write myself off. It’s like I use it as an excuse to just get fucked up” – Male (Jason)

A number of participants disclosed an inherent belief that they were “worthless” or “not enough”. Participants reported that when lonely, they could identify having thoughts about their worthiness to have others’ company, which would often make them feel more lonely.

“I’m very negative with myself so I feel like maybe I am too much, maybe I need to step back, maybe I’m not worth being a part of someone’s life. I always think of a lot of negativity; it just goes and goes and goes.” – Male (David)

Many participants also reported concerns about how others perceived them, as well as thoughts about the feeling of loneliness itself which in turn was reported to strengthen feelings of loneliness. Fear of negative evaluation was notable, with participants reporting this experience both inside and when out of the residential service.

“I really can’t share in the meeting because I’m just scared that I’m going to be judged” – Male (Nathan)

Lack of authenticity/quality in relationships.

Participants commonly recognised that their loneliness arose from the absence of connections to others that felt genuine, authentic, or like they were good quality relationships. This lack of authentic relationships was attributed to their own self-destructive behaviour in relationships, emotional barriers in efforts to self-protect, or due to the materialistic or transactional nature of some relationships. Some participants spoke about their belief that
their difficulty expressing their emotions is what ultimately caused them to feel lonely, as not sharing their feelings had often impacted the quality of their relationships.

“I engage well with people, but I just back off, you know what I mean, like, I put the brakes on.” – Male (John)

Additionally, participants spoke about their desire to self-protect as being a significant barrier to forming genuine or authentic relationships, which in turn maintained their loneliness.

“There’s a lack of safety in relationships, in being vulnerable with people” - Female (Jessica)

Loneliness was reported to arise as a result of hiding one’s addiction from family and friends, which in turn contributed to a lack of authenticity in these relationships. Many participants spoke about their connections with other substance users as often being transactional or conditional, and not truly supportive of one another, as what led to feelings of loneliness.

The effect of substance use on relationships.

The destruction that participants’ ongoing substance use had on their relationships was commonly reported. Participants spoke about family, friends and significant others having distanced themselves, both physically and emotionally, due to the individual’s substance use.

“You notice as you go to more parties you sort of get left alone a bit because, ‘He’s stoned again’. ” – Male (Kyle)

Some participants reported that they had “disengaged” with others throughout the course of their addiction and had chosen to prioritise substance use over their relationships.
Two participants discussed their choice to cut contact with their substance using peers and having consequently become lonely due to the absence of a recovery-supportive network. In contrast, two participants spoke about the function of their self-isolation as being to protect others from hurt, or to avoid exposing others to their addiction.

“I definitely isolated in the way of – I pulled back from the people that really cared about me because I didn’t want to see them, or let them see me doing what I was doing to myself, or hurt them.” – Male (Paul)

Consequences of loneliness

Not surprisingly, a number of factors that were cited as being contributors to feelings of loneliness, were also discussed as outcomes, or consequences, of loneliness. These related to dominant cognitions, as well as the affective and behavioural outcomes of feeling lonely.

Cognitions.

Aligned with the cognitive theories of loneliness, a number of participants reported that the thoughts about self and others that appeared to contribute to loneliness also grew stronger as a result of feeling lonely. In particular, when feeling lonely, participants reported that they perceived others did not care about them or were not available, or willing, to support them. A number of participants reported that when feeling lonely, they often had thoughts that they were unworthy and unloved, which in turn reinforced their loneliness. The mechanisms by which loneliness become reinforced may be explained by cognitive theory, where perceptions of low self-worth then lead to an increased hypervigilance to interpersonal threat and subsequent social withdrawal (31).

“You know, there’s a deep – a very deep sadness, of unworthiness I guess and – and – but there’s also responsibility in it too because a lot of the loneliness comes from self-destruction, in the way of relationship.” – Female (Jessica)
“So yeah, a lot of negative thoughts, mainly self-worth; the thoughts of not being worthy enough for other people’s company.” – Male (Jake)

Unhelpful interpersonal behaviours.

Half of the participants discussed their tendency to act in ways to self-protect, due to ongoing feelings of loneliness. Similar to reasons cited as a contributor to loneliness, participants reported a tendency to avoid showing emotion and being vulnerable in front of others.

“I tend to intellectualise it a bit in a group setting, so I don’t get very vulnerable very easily.” – Female (Jessica)

Participants discussed interpersonal consequences of their loneliness, including gravitation towards unhealthy relationships. A number of these relationships were described as romantic in nature, with some participants reporting their desire to be loved and to stop feeling lonely as driving them into relationships that were not healthy. Participants also described gravitation towards others in the drug using community. Most of these participants spoke about a tendency to seek out connection from any available source, despite an awareness of the destructive nature of these relationships.

“I’d just seek connection anywhere where I could get it. So, I’d be hanging out with people that, say they’d want something from me, and I’d go there, and I’d do that thing even if I didn’t want to, just so I could hang out with them afterwards. I’d compromise myself a lot just so I could get real human contact and connection.” – Male (Jason)

While participants reported their tendency to seek out unhelpful relationships to be an outcome of loneliness, lack of authenticity or quality relationships was also cited as a cause of loneliness, seemingly highlighting a vicious cycle for many people. Such experiences
highlight a discrepancy between the knowledge of what helps to alleviate loneliness, yet difficulty translating this knowledge into meaningful and helpful behaviours.

A tendency to further isolate oneself as a result of feeling lonely was described by some people. This appeared to arise from low self-worth, fear of negative evaluation, and difficulty trusting others, and involved withdrawing from others, and/or behaving in a shy, reserved manner around others.

“The loneliness, it withdraws you from everything.” – Male (Matthew)

Substance use to connect or cope.

While substance use was cited as a key cause of loneliness, it was also reported to be an outcome of feelings of loneliness for almost all participants in the study ($n = 18$). A number of participants described their initial experiences with substance use as being to facilitate social connection. In these instances, substance use was described as having a positive effect on social interactions. Prior research has also found similar outcomes in relation to social motives for substance use (e.g. 22, 37). However, in the current study, most participants described the increasing isolation that transcended as their substance use developed further into addiction.

“It was a social kind of thing and I was able to connect with people, think people were great and all that but then once, definitely once I started drinking a lot more and once I started abusing it, those kind of connections disappeared.” – Male (Nicholas)

Half of the sample cited substance use as a means of coping with distressing feelings of loneliness.

“That pit of loneliness that I had inside me that I filled that void with drugs.” – Male (Ben)
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“Because if I stay lonely, I’m probably going to go back to drugs again, even though it’s lonely while you’re on drugs too. But it’s a coping mechanism.” – Male (Nathan)

Reports of filling a “void” and “escaping” were common, where participants spoke about having no other coping mechanisms to deal with loneliness and resultantly turned to substance use. Some participants spoke about feeling lonely and as a result they began engaging in substance use, and identifying as a substance user, in order to feel that they had something in common with others, and to feel they belong.

“So I was very disconnected from a lot of people, so I started using ice and just the people that use ice as a way to get connection and get validation as a human, you know what I mean?” – Male (Jason)

“Yeah, with other addicts. It’s not like a deep meaningful friendship, but sometimes it’s the best you’re going to hope for.” – Male (John)

Alleviators of loneliness

Both females in this sample, tended to report that they believed intrinsic changes, such as becoming more vulnerable and behaving differently so as not to isolate, would be necessary to alleviate loneliness. While males also reported a belief these things would help to alleviate loneliness, they also discussed factors external to the self, such as support groups, and engagement in leisure activities as being protective against loneliness.

Overcoming cognitions.

Many participants described a belief that if they were able to be vulnerable and overcome concerns about low self-worth, being judged, trusting others and/or other’s availability for support, then this may help to alleviate loneliness. Some participants spoke about their previous experience confiding in others and how this had helped to protect them
from recurrent feelings of loneliness. Some participants also discussed the utility of “not isolating” whilst residing at the treatment centre in helping to protect against loneliness.

“It’s a very different environment [recovery service] to be in. It stops me, I guess, isolating as much as I want to in some ways, because people are checking in all the time, which is the best part of what’s good about being here... I think if I was at home, I would have picked up using again, like 100% - months and months ago. So it’s definitely better, because I do enjoy that – as I said, that less deep level but that social – sort of light level social stuff.” – Female (Jessica)

People discussed the presence of ‘opportunities’ in this context, in that there are always others to talk with, and activities to participate in, suggesting that the presence of other people potentially serves as an additional buffer against feelings of loneliness, as well as availability of support.

Support groups.

Participants reported a belief that the support groups offered at the treatment services, as well as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups external to the services were largely effective in subduing feelings of loneliness. In particular, participants appeared to attribute the sharing, and vulnerability of others during the groups, to what had facilitated the sense of connectedness in this context.

“Well, the groups are discussion based and AA and the meetings and the shares, sort of, are quite good, a little bit like hearing other people talk about their life or experiences has been helping me in that not only do I find it relatable, but you can feel some sort of connection and learn lessons from what they’ve said.” – Male (Joshua)
“I guess, the group sessions that we have. They get everyone to check in around in the group, so we all have to talk, and it helps me to get to know people and I try to start to feel a bit more comfortable and I’m a bit more at ease.” – Male (Nathan)

However, some participants reported that the sense of connection that was felt during the organised support groups seemed to dissipate once the group session was over.

“... the groups, like I say the meetings like I’m going to, to AA with people who are going to NA with people from here, even the in-house ones. I feel connected to everyone there then, as soon as we walk back out the door I kind of... but just that little brief time where everyone kind of shares how they’re feeling at this point in time, was good like I felt a bit connected and like we were bonding a little bit, just even that, but that kind of went out the window” – Male (Nicholas)

Authenticity/ quality in relationships.

Relationships that were not authentic or honest were cited as a key reason why people felt lonely, as well as a key outcome of loneliness, in terms of participants seeking out connection with anyone available to them. Most participants reported a desire for genuine, caring relationships and there appeared to be agreement that the existence of these types of relationships would, and does, alleviate feelings of loneliness.

“I really believe in a good foundation of a relationship and you know...And the relationships I have are so genuine and are real that they’re fulfilling, you know, like - - - I don’t need to go and have other relationships because I’m getting enough satisfaction from those I’ve got in a way.” – Male (Paul)
A number of participants spoke about the utility of others caring for them/supporting them in combating loneliness. Three participants alluded to staff at the treatment service as being a major source of support that has more recently helped them to feel less lonely.

“Maybe my case worker as well, he’s trying to guide me in the right way, to reach out more and talk to people if you need to. I never had support from anyone when I needed.” – Male (Brett)

Positive activities.

Some participants shared coping mechanisms, such as engaging in leisure activities, organised religious or social groups, and surrounding oneself with others. Males in this sample commonly cited keeping one’s mind active as an effective means of coping with loneliness. Rather than engaging in substance use to “escape” from loneliness, participants reported a tendency to read books, listen to music, watch TV series or engage in physical activity as methods to keep busy.

Some participants identified having a sense of purpose as protective against loneliness. In particular, these people discussed their belief that helping others, volunteering, finding enjoyment in life, and having a connection with a “higher power” (a term used in Alcoholics Anonymous/the 12-step approach that refers to any force or being that is considered to have a superior power to the self), was important for them to avoid feeling lonely.

“I think if I can be out in the world, I think that idea of service, I guess, they talk about in the rooms, getting off yourself and getting out and helping others might be a way of moving past some of the loneliness.” – Female (Jessica)
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This suggests that engagement in activities that are intrinsically meaningful and/or values congruent for the individual, may serve to protect against loneliness in the longer-term.

**Discussion**

The findings from this qualitative study suggest that cognitions play a key role in the reciprocal relationship between loneliness and SUD. The aims of the study were to identify contributors to loneliness, consequences of loneliness, and alleviators of loneliness among people with SUDs. Contributors to loneliness included unhelpful cognitions about the self and others, a lack of authenticity in relationships, and the negative effects of substance use on relationships. Consequences of loneliness related to cognitions about being unworthy or unloved, engaging in self-protective or destructive behaviours, and the use of substances to connect or cope. Participants reported that overcoming these unhelpful cognitions, support groups, and genuine relationships with others, as well as positive, meaningful activities were helpful in alleviating loneliness.

Aligned with cognitive theories of loneliness (29, 31), participants in the current study described a range of self-defeating thoughts (e.g. worthiness) and a tendency to hold negative expectations of interpersonal relationships (e.g. others will let me down, what’s the point) that appeared to contribute to feelings of loneliness. Socially and historically, addiction has been a highly stigmatised condition (16, 17). Findings from the current study suggest that the social context of addiction might impact participants’ own perceptions of themselves and others. Beliefs related to self-worth and support that were reported by participants in this study appear to be supported by findings of prior research suggesting that public stigma can be internalised (38, 39) and can undermine one’s ability to develop supportive, trusting relationships (38, 40).
While previous research has explored the role of implicit cognitions and attentional bias as SUD treatment targets (e.g. 41), there appears to have been little insight into the specific cognitions that are most dominant in driving social behaviour and contributing to ongoing substance use. Some existing research has found that maladaptive schemas, in particular disconnection and rejection schemas, are associated with substance use (40). The pattern of functioning described by participants in the current study is aligned with these previous findings. In particular, participants spoke about their difficulty trusting others which led to difficulty being vulnerable in relationships and a tendency to socially withdraw in efforts to self-protect. Participants in this study appeared to face significant challenges in attaining support both during active substance use and during recovery. In particular, participants described their relationships with other substance users as often feeling transactional and non-supportive. While in recovery, participants discussed a reluctance to rely on their peers, due to fear of having their trust broken, or fear that fellow peers may lead them back down the path of substance use. Mistrust cognitions and self-protective behaviours are commonly found among individuals who have experienced interpersonal maltreatment. Although beyond the scope of the current study, other research has found high rates of interpersonal trauma among adults in residential SUD treatment (e.g. 42), perhaps lending some explanation for the dominant cognitions and self-protective behaviours described by participants in the current study.

Social connectedness, or a lack thereof, was often reported by participants of the current study and to some extent, appeared to be used interchangeably with loneliness. This pattern reflects previous empirical findings that a lack of, or low social connectedness is correlated with loneliness (43), particularly for males (44). Our finding that participants tended to gravitate towards substance using groups in order to gain social connectedness, appears to be aligned with the Social Identity gain pathway described by previous research.
This pathway suggests that for individuals who were lacking in social relationships or supports, substance use afforded them a sense of acceptance, group membership, and identity as a substance user. While for some, cutting ties with substance using groups may be helpful for recovery maintenance, for others, substance using groups might provide an important sense of connectedness. Treatment providers might consider each individual’s unique social networks prior to encouraging their clients to cut ties with substance using groups. Use of methods such as the Social Identity Mapping tool are one means of understanding the existing networks of people with SUDs and the extent to which they identify with these networks. Additionally, treatment providers might support clients to develop skills to manage their connections with existing substance using ties, and skills to form new recovery-supportive networks. Findings from this qualitative study also suggest that the pursuit of relationships that are authentic and meaningful, as well as positive activities that provide a sense of purpose might also be helpful in preventing or reducing loneliness. In addition, the function of group contexts appears to be another important finding from this study, which has been supported by previous literature. In the current study, participants reported that organised support groups fostered a sense of connection and trust that was not attained elsewhere. Future research might benefit from adopting a framework similar to that by Borek, Abraham, which was developed to understand inter- and intra-personal facilitators of change in group interventions, such as sharing experiences, social validation and attributions. This might help to clarify the specific components of the organised support groups that foster connectedness and trust that enables individuals to genuinely participate despite their feelings of vulnerability and cognitions surrounding mistrust. While peer support was not specifically cited by participants in this study, peer support has gained recognition across the literature as positively contributing to addiction recovery outcomes. A limitation with the current study was the low proportion of
female participants. In addition, participants were accessing residential treatment services in New South Wales, Australia. While our findings revealed a number of consistent and recurrent themes related to loneliness that are likely to be geographically generalisable, they may be more representative of males with SUD. While some research has revealed loneliness to differ for males and females (e.g. 53), other quantitative studies have reported no difference in loneliness between males and females (9, 54). In the current study, very few themes emerged from our data that were gender specific. This lack of difference is likely to be accounted for by our sample. Future research efforts that aim to replicate the current findings with a large, generalisable sample, or extend these findings beyond residential treatment services would be beneficial.

To the author’s knowledge, the current research is the first to qualitatively explore the relationship between loneliness and addiction and to explore the role of cognitions in maintaining loneliness for people with substance use disorders. Loneliness is a growing problem (2) which has been deemed a public health issue (6, 55). People with substance use disorders are highly vulnerable to loneliness and there is a need for evidence-based interventions to reduce loneliness for this population (35). The current study revealed key themes related to the contributors to and consequences of loneliness for this population, which included: authenticity and quality in relationships, destructive interpersonal behaviours, and the role of loneliness in substance use. In addition, the findings of this study suggest that loneliness interventions that address cognitions related to mistrust, low self-worth, fear of negative evaluation, and perceptions of other’s willingness to offer support, as well as the identification and pursuit of meaningful relationships may be beneficial for this population, and such programs are currently being evaluated (56, 57). In doing so, the unhelpful reciprocal relationship between loneliness and substance use may be overcome.
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Table 1.

Clusters, themes and sub-themes related to loneliness

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Themes and subthemes</th>
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<tbody>
<tr>
<td>1. Contributors to loneliness</td>
<td>1.1 Cognitions</td>
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<tr>
<td></td>
<td>1.1.1 Mistrust</td>
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<td>1.1.2 Perceived lack of support</td>
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<td>1.1.3 Low self-worth</td>
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<td></td>
<td>1.1.4 Fear of negative evaluation</td>
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<td></td>
<td>1.2 Lack of authenticity/quality in relationships</td>
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<td></td>
<td>1.3 The effect of substance use on relationships</td>
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<tr>
<td>2. Consequences of loneliness</td>
<td>2.1 Cognitions</td>
</tr>
<tr>
<td></td>
<td>2.1.1 Perceived lack of support</td>
</tr>
<tr>
<td></td>
<td>2.1.2 Low self-worth</td>
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<td></td>
<td>2.2 Unhelpful interpersonal behaviours</td>
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<td>2.2.1 Self-protection</td>
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<td>2.2.2 Gravitation to unhelpful relationships</td>
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<td>2.2.3 Isolation</td>
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<td></td>
<td>2.3 Substance use to connect or cope</td>
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<tr>
<td>3. Alleviators of loneliness</td>
<td>3.1 Overcoming cognitions</td>
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<td></td>
<td>3.2 Support groups</td>
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<td></td>
<td>3.3 Authenticity/ quality in relationships</td>
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<td></td>
<td>3.4 Positive activities</td>
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