Loneliness and its association with stress and psychopathology

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Summary

Loneliness could be defined as a subjective experience in which a person feels psychological discomfort because he/she is unable to increase the quality and/or quantity of relationships to the person’s desired level. Loneliness occurs following a perceived lack of and/or loss of significant relationships and can contribute to several physical and psychological health problems. Populations at risk for loneliness include the elderly, young college students, the seriously ill, the disabled, those who experience significant loss, and those who are isolated like the psychiatric patients. Specially, people presenting with psychological problems often experience social stigmatization and isolation.

Since the patient may be reluctant to express loneliness, all the parties involved in patient’s care (physicians, mental health professionals, caregivers, family members) ought to look for the possible risk factors for loneliness, including age (elderly, young adult), recent relocation, recent death of significant other, gradual loss of important relationships over time, disabilities (intellectual or physical), serious illness, depression and other psychiatric disorders. Finally, psychological support of people suffering from loneliness may prevent further deterioration of their physical and mental health.

Key Words: loneliness, solitude, stress, psychopathology, elderly, individuals with disabilities, children, adolescents, stigma, psychosis

Introduction

Loneliness could be defined as a subjective experience in which a person feels psychological discomfort because he/she is unable to increase the quality and/or quantity of relationships to the person’s desired level (Cassidy & Asher, 1992; Peplau & Perlman, 1982). On the contrary, solitude is a state of seclusion or isolation which may be often desirable and valued as a time when one may work, think or rest without being disturbed.

Loneliness occurs following a perceived lack of and/or loss of significant relationships and can contribute to several physical and psychological health problems. Loneliness, like any situation that requires behavioral adjustment is stressful, and the fight or flight response is evoked. Walter B. Cannon described the “fight or flight” response to stress, identifying a consistent set of physiologic changes that occur when animals, including humans, are exposed to stress. (Cannon and de la Paz, 1911; Sterling and Eyer, 1988; McEwen 1998; Charney, 2004; Benson and Casey, 2008; Chrousos, 2009).

What is stress?

Stress hormones (cortisol, adrenaline and noradrenaline) prepare the body to fight or flee. Breath quickens, heart beats faster, senses are sharpened (sight and hearing), the individual become more alert, certain blood vessels constrict, which helps direct blood to the muscles and the brain and away from the skin and other organs. Body systems not needed for immediate actions are suppressed. The stomach and intestines cease operations. Sexual arousal lessens. Repair and growth of body tissues slows. Hans Selye (1956) was the first to advance the idea that physical and psychosocial stressors trigger the same physiological response. He also suggested that short-term stress (good stress) stimulates people in order to overcome obstacles while ongoing and overabundant stress (bad stress or distress) wears down the ability to adopt and cope. Two Harvard researchers Yerkes and Dodson (1908) noted that as stress or anxiety levels rose, so did performance and efficiency-up to a point. At this turning point, further stress and anxiety led to poor performance.
significant declines in performance and ability.

**Overabundant (bad) stress is linked to health problems**

Hypertension, allergic skin reactions, anxiety, arthritis, constipation, cough, depression, diabetes, dizziness, headaches, heart problems (angina, heart attack, and cardiac arrhythmia), infectious diseases such as cold and herpes, infertility, irritable bowel disease, insomnia, menopausal symptoms such as hot flashes, nausea and vomiting of pregnancy, pains (backaches, headaches, abdominal pains, muscle aches etc.), premenstrual syndrome, slow wound healing, side-effects of AIDS, cancer and cancer treatment, ulcers etc.

**Overabundant (bad) stress warning signs**

**Physical symptoms**

Tight neck and shoulders, back pain, sleep difficulties, tiredness or fatigue, racing heartbeat or palpitations, shakiness or tremor, sweating, ringing in ears, dizziness or fainting, choking sensation, difficulty swallowing, stomachache, indigestion, diarrhea or constipation, frequent urgent need to urinate, loss of interest in sex, restlessness.

**Behavioral Symptoms**

Grinding of teeth, inability to complete tasks, bossiness, fidgeting, overuse of alcohol, emotional eating or overeating, taking up smoking or smoking more than usual, increased desire to be with or withdraw from others, rumination (frequent talking about stressful situations).

**Emotional Symptoms**

Crying, irritability, edginess, anger, feeling powerless to change things, nervousness, feeling anxious, quick temper, lack of meaning in life and pursuits, boredom, loneliness, unhappiness with no clear cause, depression.

**Cognitive Symptoms**

Continual worry, poor concentration, trouble remembering things, loss of sense of humor, indecisiveness, lack of creativity, trouble thinking clearly.

**Populations at risk for loneliness**

Populations at risk for loneliness include the elderly, young college students, the seriously ill, the disabled, those who experience significant loss, and those who are isolated like the patients with psychiatric problems.

**Elderly**

Social isolation and loneliness in the elderly has been found to be associated with greater levels of stress, greater age related increases in blood pressure and diminished cardiovascular functions underlying blood pressure regulation (Hawkley and Cacioppo, 2003; Cacioppo et al., 2014) increased mortality (Seeman, 1996; Udell et al., 2012; Perissinotto et al., 2012), poor self-rated physical health (Cornwell and Waite, 2009), functional decline (Hawkley et al., 2009; Perissinotto et al., 2012), increased susceptibility to dementia (Fratiglioni et al., 2000) and the onset of disability among older males living alone (Lund et al., 2010). Furthermore, social isolation was reported to be negatively associated with health status and health-related quality of life in the elderly (Gow et al., 2007; Hawton et al., 2010).

**Children- Adolescents**

Childhood loneliness is characterised by children’s perceived dissatisfaction with aspects of their social relationships (Avramidis, 2010; Qualter et al., 2010). A recent literature review showed that about 10–15% of the children and adolescents felt very lonely (Galanaki & Vassilopoulou, 2007). During adolescence, the social expectations, roles, relationships, and personal identities of individuals undergo significant changes (Heinrich & Gullone, 2006). Social relations become increasingly important and adolescents spend considerably more time with their peers, away from adult supervision (Brown & Klute, 2003; Rubin, Bukowski, & Parker, 2006). Additionally, early adolescence coincides with the transition from elementary to secondary school. In recent years, this transition phase, which is often marked by the breakup of old friendships and forming new relationships, has been highlighted as an area of concern (Hardy, Bukowski, & Sippola, 2002; Humphrey & Ainscow, 2006). These significant changes in adolescents’ social worlds might be related to the peak in
the prevalence of loneliness during this time. Relationship issues such as poor peer and family relationship quality, difficulty being close to peers and difficulty trusting peers may predict depressive symptoms. We should also bear in mind the associations that exist between bullying perpetration, victimization, that can drive children to loneliness depression, anxiety, low self-esteem, and hopelessness (Hong et al., 2014; Nixon et al., 2014). Depression, shyness, low self-esteem, social anxiety as well as developmental changes and maturation issues might make adolescents susceptible to loneliness (Mahon et al., 2006; Laursen and Hartl, 2013 ). And vice versa, an association between loneliness in children and adolescents and adverse health outcomes has been reported, including: depression, recreational drug use, suicide ideation and violence (McWhirter et al., 2002); parasuicide and self-harm (Yang and Clum, 1994); eating disturbances, obesity and sleep disturbances (Cacioppo et al., 2000); adolescent alcohol use, general health problems, less than optimal well-being and somatic complaints (Krause-Parello, 2008) personality disorders and psychoses (Richman and Sokolove, 1992).

**Children with chronic illnesses and disabilities**

Children who are exposed to chronic illnesses (especially those that are life-threatening) are susceptible to loneliness since they might may experience sleep disturbances and nightmares, thought suppression, difficulties in concentration, memory problems, loss of motivation, intense fear, irritability, and aggression toward their parents and peers (Terr, 1991; Pine and Cohen, 2002). Furthermore, such children may develop acute stress disorder, learning disorders, regressive behaviors, somatization, dissociative disorders, separation problems, and posttraumatic stress disorder and depression (Terr, 1991; Pine and Cohen, 2002, Sawyer et al., 2007; Pao et al., 2007; Kakaki and Theleritis, 2007). Older children and adolescents may experience a loss of faith in the future because they realize that life is fragile (Terr, 1991). They may become involved in high-risk sexual behaviors as well as abuse of alcohol, illicit drugs, and tobacco, which may compromise their health status considerably, given the severity of their medical condition. (Pine and Cohen, 2002, Sawyer et al., 2007).

**Adults with chronic illnesses and disabilities**

**Patients with psychiatric problems**

Specially, people presenting with psychological problems often experience social stigmatization and isolation (Economou et al., 2009; Karidi et al., 2009, 2010). The negative social consequences of living with a psychiatric diagnosis are understood in experienced social exclusion as follows: reduced access to employment opportunities, difficulties in obtaining insurance, poverty, and depleted social networks. Self-stigma refers to a process in which patients with schizophrenia may internalize mental illness stigma and experience diminished self-esteem and self-efficacy. Self-efficacy and self-esteem are the components of self-image that are most affected by self-stigma. When a patient endorses the public stereotype about mental illness, composed of a helpless, weak or dangerous patient image, and adopts these attributes, feelings of shame, devaluation, incompetence and depression surface, undermining self-efficacy and self-esteem (Economou et al., 2009; Karidi et al., 2009, 2010).

**Individuals with disabilities**

Disabled and handicapped individuals often feel social isolated and lonely (Zhang et al., 2014; Kool et al., 2013; Harris, 2009). Self-esteem partially mediates the relationship between stigma perception and social avoidance, social anxiety and loneliness (Zhang et al., 2014). Loneliness is prevalent in individuals with rheumatic diseases. This could be due to not receiving social support and being stigmatized and invalidated, which might be most common in fibromyalgia, a rheumatic disease that lacks medical evidence (Kool et al., 2013). So, apart from patients with psychiatric problems individuals with other disabilities may also feel stigmatized and invalidated.

**How to help these people**

Since the patient may be reluctant to express loneliness, all the parties involved in patient’s care (physicians, mental health professionals, caregivers, family members) ought to look for the possible risk factors for loneliness, including age (elderly, young adult), recent relocation, recent death of significant
other, gradual loss of important relationships over time, disabilities (intellectual or physical), serious illness, depression and other psychiatric disorders. Finally, psychological support of people suffering from loneliness may prevent further deterioration of their physical and mental health.

**Elderly**

There is a great effort to reduce the feeling of loneliness in the elderly. As reported in the study by Dikkens et al. (2011), it appears that common characteristics of effective interventions which counteract loneliness in the elderly may include offering social activity and/or support within a group format. Interventions in which older people are active participants also appeared more likely to be effective. In a recent review by Hagan et al., (2014) the following four studies found that their interventions were successful in reporting significant reductions in loneliness in elderly participants. a) Creswell et al.'s (2012) Mindfulness-based stress reduction training group programme, b) Kahlbaugh et al.'s (2011) one-to-one Nintendo Wii intervention, c) Banks et al.'s (2008) introduction of either a living or robotic dog, d) Tsai & Tsai's (2011) study on videoconferencing.

**Children and young people**

Bossaert et al. (2012) report that students with disabilities or special educational needs at this age are in need of adapted types of interventions, with more focus on enhancing same-sex social self-concept and, to a lesser extent, friendship quality. Persons involved with the care of children (physicians, mental health clinicians, community health workers, teachers, caregivers, and family members) should be aware that children and adolescents with a history of exposure to trauma, prior psychopathology, and disruption in social and family support networks are particularly vulnerable to psychological trauma.

Especially for children who experience chronic or life-threatening medical conditions, preventive measures should be implemented: their mental health status, quality of life, and possibility of becoming involved in risk-taking behaviors should be regularly monitored, and any problem that arises should be promptly handled by mental health clinicians (Kakaki and Theleritis, 2007). Spiritual coping is an important predictor of mental health in youth with chronic health conditions. It may affect mental health partly by facilitating more positive interpretations of life events. Clinicians should assess for spiritual distress, particularly among youth with psychosocial adjustment difficulties or more severe conditions (Reynolds et al., 2013). These interventions might make chronic medical conditions more tolerable, both for children and adolescents and for their families. Furthermore, specialised telephone helpline could help enormously children and adolescents in need of psychological support (e.g. childline).

**Seriously ill adults**

Social support, cognitive therapy and group counseling could help disabled people (Evans et al., 1985; Kool et al., 2013).

**Psychiatric patients**

Psychosocial rehabilitation interventions could help patients with psychiatric problems. Identification with a patients' group seems to have a protective role that reduces the likelihood that an individual will agree with public stigma and experience diminished self-esteem and self-efficacy (Karidi et al. 2009, 2010). Effective psychologic interventions must deal with the patient’s reality, both the external one and the one he or she has internalized. These interventions entail both individualized and group therapy so that each patient can be supported to cope with mental illness in an efficient way.


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