**Listen to the Lonely**

*‘The most terrible poverty is loneliness, and the feeling of being unloved…’ Mother Teresa*

He was in his early twenties, and had been seeing me at the clinic for a few months. Being diagnosed with psychosis was a shock, but we had made progress: the voices in his head were less frequent, his mood had lifted somewhat and he was working towards starting a college course. It wasn’t full recovery – but it was heading in the right direction. In fact, when he returned from a Christmas break with family outside the city, he went as far as saying he was ‘happy.’ But over the following weeks and months, things went downhill again. He dropped out of the course, and though his psychiatric symptoms had all but disappeared, he struggled to find motivation and his engagement reduced. We adjusted medications, he started cognitive therapy and we began looking into yet more courses. It helped, but it was not quite enough.

He eventually revealed the most ‘awful and pathetic’ aspect of his life was neither paranoia nor being unable to work. What plagued him most and drove him to contemplate taking his own life was this: ‘I’ve got no one, no one *knows* me.’ Christmas was nice, but for the rest of the year he rarely heard from family and had no confiding relationships. His brother, who visited occasionally, had recently moved abroad. And without that sense of connection, he felt lost. Lost and lonely.

*Loneliness is not simply ‘being alone’*

Loneliness is the feeling one’s social needs are not being met by the quantity and quality of one’s social relationships. It is possible to feel lonely despite being surrounded by people: what counts is the subjective *feeling* of meaningful connection. The young man in clinic was being offered plenty of opportunities to be around people (courses/day centres), but simply populating his day with brief encounters did not reduce his deep sense of loneliness. Seeing a therapist was helpful, but certainly no substitute for the rich reciprocity of a ‘real’ relationship.

Loneliness is not *‘*solitude’ (a pleasant state of being alone) as it is, by definition, a *distressing* experience. A leading loneliness researcher, John Cacciopo at the University of Chicago, has spent decades researching loneliness and likens it to the feelings of pain, hunger or thirst. For social beings like us, chronic loneliness is an unhealthy state, with very real consequences.

*All the lonely people*

Certain population groups, such as the elderly and people with mental illness are particularly vulnerable. But levels are reportedly high right across the general population. Britain has been hailed Europe’s ‘loneliness capital’, with half of over-80s, a third of over-50s and up to 80% of 18-34-year-olds reporting feeling lonely. In a US report, one in four adults reported feeling lonely often. There are indications levels of loneliness are on the rise across the globe. This, in an era of social media and apparent ‘friends’ at the click of a button.

*Loneliness costs lives*

A recent finding, after pooling together nearly 150 international studies, was that loneliness increases one’s risk of *death* by up to 50%. That suggests loneliness is more of a public health risk than obesity or lack of exercise, and comparable to smoking fifteen cigarettes a day. It has been strongly linked to several chronic physical health problems, for example high blood pressure and asthma. People with cancer appear to do worse if they are lonely, compared with those who are not, as is the case for heart disease.

Scientists believe the brain is where our social ‘data’ gets processed, so it is not surprising there are links between being lonely and mental health. An American study of over 800 elderly people followed up over time, showed the loneliest were nearly twice as likely to develop Alzheimer’s dementia.

There is also a large body of evidence showing a relationship between loneliness and depression. Interestingly, being lonely meant you were more likely to become depressed but being depressed also made your loneliness worse. Of concern, loneliness has been shown to be an important factor in suicide. To me, these statistics highlight a need for loneliness to be a real public health priority.

*So what now?*

As a psychiatrist, my immediate response to suffering tends to be one of empathy, combined with a strong desire to do something about it. That is quite distinct from over-medicalising (I don’t believe we need to consider loneliness as disease per se) and this is a scenario where individual circumstances and experiences of loneliness are crucial in shaping how one tackles it.

As a scientist, I look to take what we know from research and translate that in the most appropriate way to something meaningful and acceptable to the patient. The evidence base for interventions in loneliness is surprisingly limited, but growing. In mental illness, most studies have looked at either social recreation groups or individual therapy focusing on how the lonely person ‘reads’ other people – and how this might be maintaining their situation. The results so far are mixed, and there is certainly a need for larger, better-designed trials to tease out what works best.

Professor Cacioppo has recommended the ‘EASE’ approach for anybody wishing to tackle loneliness:

E – EXTEND YOURSELF: take little steps to stretch yourself and experience social interaction in relatively ‘safe’ settings, this should increase your experience of the positive aspects of connecting with others without overwhelming you

A – ACTION PLAN: recognise that you do have control over your social situation and changing your attitudes, behaviours and expectations of others even slightly can have a dramatic impact. Remember also that you can make active choices about the social settings you choose to be in

S – SELECTION: don’t assume you have to get in with everyone all the time, spend time with people you genuinely find common ground with and focus on strengthening these connections

E- EXPECT THE BEST: a positive and warm attitude tends to elicit the same in others

For my client, an intervention he found helpful was inviting his brother to a joint meeting, where we discussed the positive impact time with his family had on him. Talking about it was a first step in addressing this need. He is still recovering, but now volunteers at a city farm and his family have made a concerted effort to check in with him on a regular basis. For many others, unfortunately, loneliness remains a shameful secret with potentially lethal consequences.

Farhana Mann

Clinical Training Fellow and Specialist Registrar in Psychiatry (ST6)

Division of Psychiatry, University College London