

Loneliness and the Prospect of Abstinence in Addicts in the Context of the Ecosystem Meta-theory of Social Work

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BACKGROUND: Studies around the world point out that there is a significant relationship between loneliness and different types of substance and non-substance addiction. Different types of loneliness are caused by different factors and reflect a significant quantitative and/or qualitative deficit in the area of basic human needs, specifically affiliation, intimacy, and love. The multi-dimensional phenomenon of loneliness can precede substance or non-substance addiction, develop simultaneously, emerge as a consequence, and prevent abstinence. The ecosystem meta-theoretical framework considers the complexity of loneliness and addiction as phenomena and conceptualises the relationships between a person's internal experience and their social and physical environment. **AIMS:** The primary goal of the pilot study is to verify the relationships among different constructs of loneliness and affinity in parallel. The secondary goal was to explore the possible differences in the measured constructs between currently hospitalised respondents and abstaining respondents.

METHODS: The quantitative test battery consisted of the

UCLA loneliness scale, T-98 social inclusion questionnaire, de Jong Gierveld loneliness scale, and MOS anticipated social support survey. **SAMPLE:** 54 respondents participated in the research. At the time, 28 respondents were hospitalised in the Košice Drug Addiction Treatment Centre (CPLDZ) and 26 were abstaining A-club members from psychotherapy and self-help groups. The research subjects were males (n=38) and females (n=16) aged 22 to 79. **RESULTS:** The mutual correlation of the tests showed medium to strong correlation. The comparison of respondent subgroups showed statistically significant differences in the individual criteria pertaining to loneliness, affiliation, and anticipated social support. **CONCLUSIONS:** Theoretical triangulation and parallel tests support the assumption that social and emotional isolation represent important factors in the treatment and abstinence prognosis. Further data analysis will be of key importance in the selection of the most suitable tests, with the emphasis on the extent of the whole battery. More detailed testing based on diagnostic as well as demographic criteria will also be necessary.

Keywords | Loneliness – Substance and non-substance addiction – Abstinence – Ecosystem – Social work

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● 1 INTRODUCTION

“Loneliness” is a specific phenomenon of human existence; however, the term is often incorrectly used to express and describe a whole range of emotions and situations such as anxiety, depression, sadness, emptiness, loss of meaning in life, solitude, etc., although loneliness as such is very specific. These conditions share certain characteristics with loneliness; however, the causes as well as consequences may differ, influence or condition each other, and precede one another. Because of this affinity, it is necessary to distinguish loneliness from other emotional states. Clinical studies point out that loneliness and issues or deficiencies in social and close intimate relationships are significant negative factors increasing the risk of relapse that may encourage the development of addiction and complicate the therapy (Medora & Woodward, 1991; Rokach, 2002; Orzeck & Rokach, 2004; Akerlind & Hornquist, 1992; Rokach, 2018).

1.1 Loneliness

On the basis of his own research and reflection on others' work in the area of analytical and therapeutic usefulness (Fromm-Reichmann, 1959; Parkes, 1985; Leiderman, 1969; Sullivan, 1953, etc.), Weiss (1985a, b, c) defines two types of loneliness related to 1) emotional isolation and 2) social isolation. Loneliness resulting from emotional isolation results from the loss or lack of intimate attachment. The fear of being neglected, losing security, but also intimacy and being hurt resulting from loneliness resulting from emotional isolation reflects the *child's first attachment*. This characterises the person's intimate relationships. In this respect, Weiss's interaction-based view corresponds with the psychodynamic loneliness model. In psychodynamics, loneliness is understood as a negative subjective experience rooted in early childhood and caused by a dysfunctional, inadequate, or absent relationship with the person who was supposed to fulfil the child's needs to a sufficient extent and duration (Sullivan, 1953; Bowlby, 1985; Weiss, 1985b). The injury caused by loneliness resulting from emotional isolation is hard to heal, and it is necessary to establish a sufficiently strong and intense connection with another person. This type of relationship cannot be substituted for by other types of relationships (Weiss, 1985b; Bowlby, 1985). *Loneliness resulting from social isolation* results from the absence of a social network of peers, colleagues, neighbours, family, or friends in which a person can participate and engage. Any severe disruption of social roles and statuses may result in loneliness resulting from social isolation. A broad range of events can cause a mental load which loneliness exacerbates further. In fact, everything that results in the loss of contact with people sharing the same interests can lead to loneliness resulting from social isolation. The symptoms of loneliness resulting from social isolation can be expected in a number of groups, e.g. divorcees, unemployed persons, those who move to live in another place, people whose behaviour and values differ from those of their surroundings, stigmatised persons (health disadvantage, minority religion, ethnic or racial identity, age – specifically seniors, minority sexual orienta-

tion, etc.) (Weiss, 1985c). People suffering from substance or non-substance addiction, those who have undergone primary treatment, and abstainers represent a specific group. Within the majority population, these people are often labelled (the labelling theory) as “addicts”, “alcoholics”, “gamblers”, and so on. The stigma grows in extent as well as negative connotations if the abstaining addict refrains from all pathological relationships with their drug-related peer group and tries to create a new, functioning social group to receive appropriate social support. The transitional period between breaking the dysfunctional contacts and making new ones can potentially result in significant loneliness resulting from social isolation. The risk that the abstaining addict will be feeling so lonely that they will return to their original, still existing, although pathological social network significantly increases. Kelly, Stout, Magilm, and Tonigan (2011) state that participation in abstaining addict groups supports the creation of new social attachments with other abstainers, thus eliminating the influence of the original social network consisting of alcohol abusers. The results show that self-help abstainer groups clearly influence the prevention of relapse and their prospects for abstinence in a positive way.

1.2 Loneliness as a relapse risk factor

Dimeff and Marlatt (1995) define relapse as a process in which cognitive, behavioural, and affective components condition one another. The process leading to a lapse in abstinence begins several weeks before the drug is actually taken. The relapse, as such, results from a generally imbalanced lifestyle that leads to specific, high-risk situations that jeopardise the individual's self-control and eventually break their abstinence. The aforementioned authors specify three categories of risky situations:

- a** | more than a third of all relapses are caused by *negative emotional states*. These states are usually related to interpersonal relationships. Such mental states include frustration, aggression, depression, apathy, fear, anxiety, boredom, etc.;
- b** | *interpersonal conflicts* cause approximately 16% of relapses; these include negative and conflicting relationships with significant others, friends, or relatives, but also confrontations at work or other types of social interaction;
- c** | *social pressure* causes as many as 20% of all relapses. Social pressure can be *direct*, from the “old drug peer group”, or *indirect*, where alcohol is a part of a social event.

The risk situations are often emotionally charged, which can trigger a strong urge in the individual to take the drug to release the tension caused by the negative emotional state they are experiencing. Loneliness resulting from both social and emotional isolation as a negative emotional state belongs to the first two categories of risk situations (Weiss 1985a, b, c). Dimeff and Marlatt (1995) do not directly state loneliness as a risk factor in breaking abstinence; however, they describe certain mental states and symptoms related to loneliness. In terms of the *ecosystem meta-theory in social work*, the aforementioned risk situations and negative emotion-

al states can be labelled as *life stressors* and *stressful situations*. *Managing stressful situations* and *coping strategies* are determined by personal characteristics as well as the dynamically developing system of their life environment and transactions between their physical and social environment. Life stressors take the form of actual or perceived harm or loss, e.g. disease, death, loss of job, difficult life changes, interpersonal and intrapersonal conflicts, broad ranges of stressful situations, traumatising situations, difficult life situations of variable quality and quantity, including *loneliness resulting from social and emotional isolation* and abstaining from *psychoactive substances* and *managing craving*. *Managing craving* and abstinence often represent *critical stressful situations* in which the person cannot rely on their previous patterns of behaviour, thinking, and feeling. Different conditions create acute and/or chronic stressful situations, which can accumulate. The resulting stress is generated internally and manifests in the form of physiological and/or mental consequences (Gitterman & Germain, 2011; Weiss, 1985a, b, c; Nešpor, 2011). From the holistic point of view, if stressful situations or stress of an inescapable nature remains unmanaged, it disrupts emotions and causes problematic behaviour; these emotions and behaviour affect the individual's internal conviction, thus creating circular causality (Ellis & MacLaren, 2005, pp. 39–43). Physiological and emotional tension result from anticipation, internal interpretation of the way the surrounding reality is constructed, and intuitive or justified evaluation of the surrounding structures, based on which the difficult life conditions, traumatising events, environmental and/or in pressure exceed the perceived available personal and/or environmental resources for managing particular situations and conditions (Gitterman & Germain, 2011).

● 2 RESEARCH METHODS

A quantitative research design was selected for the pilot study. Data was collected using a test battery consisting of the following tests:

1 | **UCLA** – Loneliness Scale (Version 3) (US). The one-dimensional scale evaluates the subjective feeling of loneliness resulting from social isolation. The questionnaire consists of 20 items. The questions describe how a person sometimes feels (“How often do you feel...”). The answers are scaled as follows: 1 – never, 2 – rarely, 3 – sometimes, 4 – always. The higher the score, the higher the loneliness experienced (Russell, 1996).

2 | **T-98** – Social inclusion questionnaire (SK). The **achieved social inclusion (ASI)** part of the questionnaire observes the behavioural aspect of affiliation; the **desired social inclusion (DSI)** part observes the motivational level of affiliation. The total number of items in the questionnaire is 30, with dichotomous coding: yes – 1, no – 0. The parts can be evaluated independently or compared. If the behavioural aspect of affiliation (ASI) is significantly lower than the motivational one (DSI), the individual may be feeling lonely (negative difference between the two scores). If the difference between the ASI and DSI scores equals zero, the in-

dividual should be subjectively feeling satisfied with their social interactions. Further interpretations depend upon the difference and direction between the ASI and DSI scores (Kolárik, 2008).

3 | **OESL** – Overall, Emotional, Social Loneliness (NL). The scale for social, emotional, and overall rates of loneliness. The questionnaire consists of 11 items with answers scaled as follows: 1 – definitely yes, 2 – yes, 3 – more or less, 4 – no, 5 – definitely not. The questionnaire evaluates the *social and emotional subscales of loneliness*. Their sum expresses the *overall rate of loneliness*. The questions examine the situations experienced by the individual and the way they feel about them. The lower the score, the higher the rate of loneliness experienced (de Jong Gierveld & Tilburg, 1999).

4 | **MOS** – The MOS Social Support Survey focuses on the estimated rate of expected social support (CZ). The questions examine how often there is another person available for the individual if they need help or support from friends and relatives or from other people. The answers are scaled as follows: 1 – never, 2 – rarely, 3 – sometimes, 4 – usually, 5 – always. The higher the score, the higher the rate of expected support. The Czech version used includes three subscales: an understanding authority, emotional closeness, and practical intervention. The American version of the questionnaire includes as subscales tangible support, affection support, positive social interaction, and emotional and information support. The American version of the questionnaire showed a statistically significant negative correlation with loneliness. In terms of Pearson's coefficient, the whole original version correlated with loneliness as follows: $r = -0.67$ ($p < 0.01$) (Kožený & Tišanská, 2003; Sherbourne & Stewart, 1991). The data was analysed and statistically processed using the IBM SPSS 20 program.

● 3 RESEARCH SAMPLE

The research involved available, non-proportional quota sampling (Hendl, 2009). The total sample consisted of 54 respondents; permission was obtained to select them from the Košice Drug Addiction Treatment Centre and self-help and psychotherapy groups for abstaining alcoholics and persons addicted to other psychoactive substances. The questionnaires were administered in person, with the assistance of the health care staff. The respondents participated in the research voluntarily and anonymously. The research sample consisted of 38 men and 16 women; average age: $x=45.6$, $Med(x)=45$; age range: 22 to 79. 28 respondents were hospitalised at the time because of substance or non-substance addiction; 26 respondents were abstaining while being provided with aftercare and attending self-help or psychotherapy groups. Since the sociodemographic questions were not answered by all the respondents, the individual summaries may not correspond with the total number of respondents. As for the weaknesses of the pilot study, the substance and non-substance addictions were not differentiated, nor were the diagnoses categorised according to MKCH-10-SK-2016. Other observed demographic data can be found in *Table 1*.

● 4 STATISTICAL PROCESSING AND INTERPRETATION OF RESULTS

Since the test battery was quite extensive (110 test questions in total plus demographic data), some respondents failed to answer all the questions in the individual tests or demographic data surveys. Only the batteries in which at least some tests could be evaluated and sociodemographic characteristics were provided were processed. The results of the individual statistical processing therefore differed in terms of the number of files that were processed and compared.

The main goal of the pilot study was to identify the strength of the relationship between individual constructs pertaining to loneliness, and to assess their relationships to constructs with shared affinity. Because of the nature of the data distribution, size of the total research sample, and size of the groups compared – consisting of hospitalised and abstaining respondents, the alternative Spearman's correlation coefficient (correlation) and Mann-Whitney U-test (causal-comparative processing) were selected. The data was analysed using the IBM SPSS 20 program.

Table 2 shows the mutual comparison of the individual tests used. The UCLA Loneliness Scale (Version 3) shows medium to strong correlation with all tests, except for the motivational affiliation component in T-98 DSI. The MOS and OESL surveys correlate in individual dimensions as well as the total score and show medium to strong relationships, except for the dimensions of practical intervention (MOS) and so-

cial loneliness (OESL), which show weak correlation. On the basis of the theoretical constructs pertaining to loneliness and related concepts, it can be stated that the researchers' assumptions about the mutual relationships between the variables that were studied were supported.

The secondary goal of the pilot study was to explore the possible statistically significant differences in the measured constructs between the currently hospitalised and abstaining respondents. On the basis of research abroad, as well as the theoretical analysis of loneliness, it was assumed that the addicts, specifically the currently hospitalised respondents, are experiencing loneliness to a larger extent than the abstaining ones who are receiving after-care. Table 3 shows the statistical comparison between the groups of hospitalised and abstaining respondents in the variables that were examined. The assumptions were partially supported. In terms of statistics, significant differences were identified in most of the variables that were examined (see Table 3); however, the results need to be approached critically because of the size of the research sample and non-normal data distribution. Despite the rather vague results of the statistical comparison, the direction of the main research can be established.

The main research to which this case study pertains aims to identify the way different types of loneliness and related phenomena change in the addicts throughout the treatment process and aftercare in relation to their prospects for abstinence. Another goal of the main research is to perform a causal-comparative investigation of the relationships be-

| | | | hospitalised | abstaining | total |
|------------------------|-----------------------|---|---------------------|-------------------|--------------|
| gender | male | | 21 | 17 | 38 |
| | female | | 7 | 9 | 16 |
| | total | | 28 | 26 | 54 |
| marital status | single | | 10 | 9 | 38 |
| | married | | 3 | 9 | 16 |
| | divorced | | 8 | 7 | 15 |
| | in other relationship | | 2 | 0 | 2 |
| | widow(er) | | 2 | 1 | 3 |
| household type | alone | | 6 | 8 | 14 |
| | other members | | 20 | 18 | 38 |
| job status | student | A | 0 | 2 | 2 |
| | | N | 23 | 24 | 47 |
| | employed | A | 13 | 18 | 31 |
| | | N | 15 | 8 | 23 |
| duration of abstinence | 0–12 | | | 14 | 14 |
| | 13–36 | | | 5 | 5 |
| | 37–72 | | | 1 | 1 |
| | 73≤ | | | 6 | 6 |
| abstinence broken | yes | | | 6 | 6 |
| | no | | | 19 | 19 |

Table 1 | Respondents' sociodemographic data

| | | UCLA | ASI | DSI | OESL – em. | OESL – soc. | OESL – tot. | MOS – pract. int. | MOS – em. clos. | MOS – und. auth. | MOS tot. |
|--|-------------------|-----------------|---------|---------|------------|-------------|-------------|-------------------|-----------------|------------------|----------|
| Spearman's correlation coefficient p (rho) | ASI | Cor. Coef. | -.397** | | | | | | | | |
| | | Sig. (2-tailed) | .003 | | | | | | | | |
| | | N | 54 | | | | | | | | |
| | DSI | Cor. Coef. | .257 | -.195 | | | | | | | |
| | | Sig. (2-tailed) | .060 | .157 | | | | | | | |
| | | N | 54 | 54 | | | | | | | |
| | OESL – em. | Cor. Coef. | -.543** | .307* | -.451** | | | | | | |
| | | Sig. (2-tailed) | .000 | .024 | .001 | | | | | | |
| | | N | 54 | 54 | 54 | | | | | | |
| | OESL – soc. | Cor. Coef. | -.534** | .437** | -.171 | .348** | | | | | |
| | | Sig. (2-tailed) | .000 | .001 | .216 | .010 | | | | | |
| | | N | 54 | 54 | 54 | 54 | | | | | |
| | OESL – tot. | Cor. Coef. | -.626** | .484** | -.362** | .805** | .791** | | | | |
| | | Sig. (2-tailed) | .000 | .000 | .007 | .000 | .000 | | | | |
| | | N | 54 | 54 | 54 | 54 | 54 | | | | |
| | MOS – pract. int. | Cor. Coef. | -.441** | .302* | -.200 | .395** | .291* | .404** | | | |
| | | Sig. (2-tailed) | .001 | .029 | .155 | .004 | .036 | .003 | | | |
| | | N | 52 | 52 | 52 | 52 | 52 | 52 | | | |
| MOS – em. clos. | Cor. Coef. | -.485** | .419** | -.046 | .516** | .380** | .537** | .504** | | | |
| | Sig. (2-tailed) | .000 | .002 | .745 | .000 | .005 | .000 | .000 | | | |
| | N | 52 | 52 | 52 | 52 | 52 | 52 | 52 | | | |
| MOS – und. auth. | Cor. Coef. | -.560** | .421** | -.057 | .553** | .500** | .625** | .635** | .826** | | |
| | Sig. (2-tailed) | .000 | .002 | .693 | .000 | .000 | .000 | .000 | .000 | | |
| | N | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | | |
| MOS tot. | Cor. Coef. | -.540** | .401** | -.068 | .544** | .433** | .588** | .770** | .852** | .961** | |
| | Sig. (2-tailed) | .000 | .004 | .638 | .000 | .002 | .000 | .000 | .000 | .000 | |
| | N | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | 51 | |
| ASI- DSI (difference) | Cor. Coef. | -.420** | .860** | -.636** | .462** | .455** | .573** | .312* | .372** | .353* | .341* |
| | Sig. (2-tailed) | .002 | .000 | .000 | .000 | .001 | .000 | .025 | .007 | .011 | .014 |
| | N | 54 | 54 | 54 | 54 | 54 | 54 | 52 | 52 | 51 | 51 |

**. $p(\alpha) < 0.01$; *. $p(\alpha) < 0.05$

Table 2 | Correlation between individual tests

| H/A | UCLA | ASI | DSI | OESL – em. | OESL – soc. | OESL – tot. | MOS – pract. int. | MOS – em. clos. | MOS – und. auth. | MOS tot. | ASI- DSI (difference) |
|------------------------|---------|---------|---------|------------|-------------|-------------|-------------------|-----------------|------------------|----------|-----------------------|
| Mann-Whitney U | 237.000 | 186.500 | 224.500 | 171.000 | 316.500 | 201.000 | 230.500 | 278.500 | 219.000 | 222.500 | 175.000 |
| Z | -2.202 | -3.077 | -2.422 | -3.356 | -.825 | -2.827 | -1.973 | -1.093 | -2.000 | -1.933 | -3.274 |
| Asymp. Sig. (2-tailed) | .028* | .002** | .015** | .001*** | .409 | .005*** | .048* | .274 | .045* | .053 | .001*** |

***.p(α)<0.001; **.p(α)<0.025; *.p(α)<0.05

Table 3 | Non-parametric tests – hospitalised/abstaining

tween the loneliness experienced and the risk of breaking abstinence. The differences between males and females will also be studied. Other demographic characteristics will be observed to determine whether they can be a moderating factor in the loneliness experienced, thus influencing the risk of breaking abstinence. As a secondary goal, the differences between the psychoactive substance addicts with selected diagnoses and non-substance (process) addicts will be looked into.

● 5 LIMITS AND RESTRICTIONS OF THE PILOT STUDY

The main limiting factor in causal comparative research is the number of respondents. It relates to the duration of abstinence in relation to the loneliness experienced, which may generate different rates of breaking abstinence. It is assumed that the rate of loneliness experienced will decrease as the duration of abstinence increases, thus also probably reducing the risk of breaking abstinence. The pilot study is also limited by the fact that substance and non-substance addiction were not differentiated. It is assumed that individual groups may differ in terms of the rate of loneliness experienced. Significant differences may be shown mainly by non-substance addiction related to use of the Internet in comparison with e.g. alcohol addiction. The assumption also applies to the fact that alcohol addicts often participate in actual social networks (although pathological) with other addicts. On the other hand, it can be assumed that process addicts (Internet-related) tend to form non-physical relationships which may isolate them more, which can manifest itself in the total score in some tests. The results of the pilot study are limited in further ways. The number of respondents within the individual groups based on sociodemographic characteristics prevented more detailed statistical processing, although that was not the goal of the pilot study. However, it is assumed that the sociodemographic characteristics will play the role of moderating variables in the relationship between the addiction, duration of abstinence, breaking abstinence, individual constructs pertaining to loneliness, and related phenomena. It is also important to perceive the results of the causal-comparative investigation as approximate, with the emphasis on the limiting aspects of

diagnostic and demographic characteristics; in the main research, these limitations will be minimised as far as possible.

● 6 DISCUSSION

The UCLA Loneliness Scale (Version 3) and OESL (Overall, Emotional, Social Loneliness Scale) test instruments were explicitly designed for measuring loneliness. The MOS anticipated social support survey focuses on the functional aspects of social relationships; T-98 identifies the behavioural and motivational aspects of affiliation. The aforementioned constructs and concept mutually reflect different constructs pertaining to concepts of loneliness and affinity related to close intimate and social relationships. Using their own questionnaire verified by a comparison with the older version of the UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980), Medora and Woodward (1991) confirmed a negative relationship between loneliness and marital satisfaction, and loneliness and self-respect in alcohol addicts undergoing treatment. The authors also revealed that female alcohol addicts are lonelier than their male counterparts. They compared alcohol-addicted respondents to other groups of the population and found that alcohol addicts are lonelier than e.g. seniors (in general), widows, divorcees, single mothers with low incomes, etc. Rokach (2002) provided the results of a comparison between three groups of young adults: users of MDMA (methylenedioxyamphetamine; known as ecstasy), non-DMA drug users, and the general population of young adults who do not use drugs. The research focused on personality and developmental deficiencies, unsatisfying intimate relationships, moving, separation, and social exclusion. It showed significant differences between all the groups within all five factors. In a similar study, Orzeck and Rokach (2004) compared the multi-dimensional experience of loneliness in three groups: detoxifying opiate users, participants in a methadone substitution programme, and non-users. Again, significant differences were found between the groups, and the most pronounced ones were identified between the detoxifying users and the non-users – in the dimensions of loneliness experienced. The aforementioned studies showed differences between psychoactive substance addicts; however, the main assumption of the present research is as follows: addicts experience various kinds of loneliness more than abstainers, regardless of the type of addiction diagnosed. A more detailed analysis

of the loneliness that is experienced which focuses on the individual substance addiction diagnoses may provide interesting results; however, it is not the goal of this research. A specific group is represented by non-substance addictions, specifically behavioural Internet-related ones (Young, 1998; Patarák, 2016; Patarák, 2018). Loneliness emerges as a by-product of excessive Internet use when an individual dedicates inordinately more time to virtual relationships than to real ones; on the other hand, lonely individuals use online activities to make contact with other users and communities through the Internet (Morahan-Martin, 1999). Using the UCLA Loneliness Scale (Version 3), Morahan-Martin and Schumacher (2003) divided 277 university students into those identifying as lonely and as not lonely. The lonely ones used the Internet to cope with anxiety, get emotional support, look for online friends, or modify their negative moods significantly more than their counterparts, which in turn disrupted their day-to-day functioning. Addiction (substance and non-substance) and loneliness are stressful situations, phenomena that are very complex, mutually interconnected, and potentially condition each other in human life. Loneliness and addiction often appear simultaneously, and it is hard to tell the cause from the consequence. Loneliness increases as the addictive behaviour and negative internal experience develop. Substance and non-substance addictions have similar characteristics in terms of their development and symptoms across the individual di-

agnoses pertaining to the addiction syndrome. Despite their similarities, the loneliness accompanying either of them has specific features.

● 7 CONCLUSION

So far, the parallel testing of the individual instruments has justified the researchers' assumptions about loneliness in relation to other affinity constructions or concepts in the context of the prospects for abstinence. The findings should set the direction of the main research in terms of selection of the appropriate tools for measuring loneliness and help determine which diagnostic and demographic variables should be observed. Studying loneliness is important because different forms of loneliness reflect specific deficiencies in our basic human needs. The failure to satisfy one's basic human needs for cohesion, belonging, affiliation, intimacy, and love makes individuals alienated, lonely, and isolated from the rest of the world and from their own internal experience, and that may result in pathological behaviour. The ecosystem framework of the life environment structure, the social environment, formal as well as informal networks, and close intimate relationships significantly influence how people cope with addiction treatment and accept a specific diagnosis and a new lifestyle aimed at abstinence.

Authors' contribution: Ján Kahan, a PhD candidate, designed the pilot study project as the main part of his dissertation. He also performed the literature review, designed the research, collected and evaluated the data, and processed the manuscript. Eva Žiaková, as his supervisor, supervised the research process and reviewed the manuscript. Both authors agree with the present version of the manuscript.

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NEWS

● TENTH EUSPR CONFERENCE AND MEMBERS' MEETING, GHENT, BELGIUM

The European Society for Prevention Research (EUSPR) promotes the development of prevention science and its application to practice so as to promote human health and well-being through high quality research, evidence based interventions, policies and practices.

EUSPR 2019 is being held in Ghent, Belgium on 16th and 17th September 2019, with workshops and project meet-

ings scheduled for the 18th. The theme this year is 'Looking over the Wall' and keynotes and special sessions will focus on optimising cross-disciplinary working and improving the ways in which different groups in the prevention field – practitioners, policy makers, researchers, communities – can work together.

New conference website for all information on EUSPR 2019: <https://eusprconference.com/>