# SOCIAL WORKERS' COMPETENCE METATHEORY IN THE CONTEXT OF WORKING WITH ADDICTS AT RISK OF LONELINESS DUE TO SOCIAL ISOLATION

[a]JÁN KAHAN, [b]EVA ŽIAKOVÁ

*Pavol Jozef Šafárik University in Košice, Faculty of Arts, Department of Social Work, Moyzesova 9, 040 11 Košice, Slovak Republic*
*email: [a]jankokahan@gmail.com, [b]eva.ziakova@upjs.sk*

The article entitled *Social Workers' Competence Metatheory in the Context of Working with Addicts at Risk of Loneliness Due to Social Isolation* pertains to the Vega No. 1/0285/18 *Rizikové správanie adolescentov ako klientov sociálnej práce v dôsledku ich osamelosti/Risk Behaviour in Adolescents as Social Work Clients as a Consequence of Loneliness* project.

Abstract: Addiction is a complex issue, which requires integration of multiple theories. In the work with an addicted client, social work employs several theories simultaneously and the process of metatheoretical thinking implicitly ensues. The research focused on measuring the levels of social loneliness experienced by substance-addicted clients during the treatment and its follow-up. The total research sample consisted of 235 addicted respondents divided into those i) hospitalised and ii) abstaining at the time. Several tests were used to identify statistically significant differences in experiencing loneliness due to social isolation. Social loneliness is a significant risk factor during treatment and its follow up in terms of abstinence.

Keywords: Metatheory. Social Work. Social Loneliness. Substance Addiction.

## 1 Introduction

In terms of research and clinical practice, social work follows relevant theories, paradigms, and philosophical basis. In clinical practice, theories represent guidelines for case analysis, social diagnostics, and planning work with the client as well as the social intervention procedure. As all scholarly fields, social work has attributes that define it as a research-based system. It has its own research subject, which differentiates it from other scholarly fields, specific research methods and procedures, and specialised functions implemented in terms of research as well as in a broad range of practical and clinical activities. Last but not least, social work formulates its own scientific rules that characterise it. The subject of social work research is the social reality as a specific form of human existence within an ecosystem. Since social phenomena are relative, it is impossible to achieve ultimate knowledge; not even paradigms as the broadest thinking frameworks for tackling the research problems can be applied without reserve.

## 2 Metatheory, theory, model

Metatheory allows for theoretical thinking about a phenomenon (Lawler, Ford 1993). Wallis (2010) defines metatheory as a stage in which a specific theory is analysed, developed, and combined with other theories. Metatheory determines the conditions upon which general prospects are formed as well as the way the questions regarding the nature of reality, human as an entity, nature of knowledge, significance of theory and research, values and ethics, and the nature of power are answered (Dervin 2003). Metatheory is also understood as the philosophy behind a specific theory that represents the way the respective phenomena are examined and processed (Bates 2005). Constructivism, social constructivism, feminism, phenomenology, postmodernism, system and ecosystem meta-theory are examples of metatheoretical frameworks employed by social work. Meatheory represents a set of basic ideas on how to perceive and examine certain phenomena – the subject of research (Vakkari 1997). It is created through examination, analysis, and description of a theory (theories) (Bates 2005). *Theories* are sets of generally accepted principles and procedural rules related to the practice (ethos), which are used to explain human thinking, emotions, and behaviour including the causes of dynamic changes in the social and physical environment. Theories are not static. They result from processes that are constantly taking place (research & practice) – theories are based on evidence. Research is also a continuous process, always developing and providing new data for the existing database of theoretical knowledge (Barth 2014; Payne 2014). Interconnecting theory and practice is not a linear process of deduction and induction – it is a complex process of responding to current ideas and social needs (Payne 2014). Theory resembles a compass that connects the helping professional with the practice (Ellis, Ellis 2013; Blackburn 2008). *Models* are irreplaceable in science. Their role is heuristic as they represent the structure of knowledge and the ways certain phenomena as well as systems behave; based on models, scientific explanations can be derived. Models always simplify the reality–, they isolate certain aspects and abstract them from individual cases. In a sense, models substitute theory or their significant parts, i.e. models are constructs created based on theories. *Testing theoretical models* are used to verify the consistency of axiomatised systems. *Confirmation theoretical models* study deductive relationships within the structure of a system (Blackburn 2008; Jandourek 2007; Ludewig 2011; Navrátil 2013a). A *practical model of social work* provides the social worker with a systematic, analytic framework, which enables them to evaluate the client's situation, identify their immediate needs, and resources or their lack thereof (Payne 2014; Galvani 2012; Navrátil 2013b). In this context, a paradigm integrates metatheory, theories, methodology, and ethos (Bates 2005). Different psychological theories employed by social work are usually referred to as "waves". The first wave includes psychodynamic theories (Adlerian, psychoanalytical); the second wave includes learning theories (behavioural, cognitive, cognitive-behavioural); the third wave includes humanistic theories (anthropocentric approach, existential theories, Gestalt theory, psychotherapy); the fourth wave is characterised by feminist and multicultural theories, and the fifth wave is represented by postmodern and constructivist theories (Ellis, Ellis 2013). The aforementioned categorisation is merely approximate as it is difficult to specify precise and absolute borders between theories. Individual theories determine, enrich, influence and integrate one another to different extents, which happens within a field as well as among different sciences. For example, Ellis, Ellis (2013) and Ellis, MacLaren (2005) refer to the *Rational Emotive Behavior Theory/Therapy (REBT)* that helped establish a multimodal, integrative therapeutic approach; it was the first modern cognitive-behavioural theory with significant therapeutic approach. Ellis, Ellis (2013) and Ellis, MacLaren (2005) also consider REBT a postmodern, constructivist therapy, which draws from philosophy rather than psychology; it takes into account multicultural aspect and is interconnected with psychodynamic and psychoanalytical therapy, systemic and family therapy. Specifically, it draws from the existential theory and REBT is considered one of the most humanistic psychological approaches (Ellis, Ellis 2013, p. 35). Based on this, it could be said that the rational emotive behavior therapy is the rational emotive behavior metatheory as a theory about the aforementioned theories in their practical contexts.

## 3 Loneliness due to social isolation

Most theoretical starting points, clinical studies, and empirical research define loneliness as intense experience, a subjectively perceived state in which a person suffers from severe quantitative and/or quantitative deprivation in terms of intimate and social relationships (Bowman 1955; Brenner 1974; Cacioppo, Patrick 2008; De Jong Gierveld 1987; Fromm-Reichmann 1959; Perlman, Peplau 1982; Rogers 1961, 1973, 1999; Sullivan 1953; Slater 1990; Weiss 1985a,b,c; Zilboorg 1938; Žiaková 2008). However, quality of interpersonal relationships is more important than their quantity (Cacioppo, Hawkley, Kalil, Hughes, Waite, Thisted 2008).

Tab. 1 Approaches to loneliness

| Approach | Starting points | Characteristics | | Causes | |
|---|---|---|---|---|---|
| | | Positive | normality/ pathology | personal/situational/genetic | history, childhood/ present day |
| Psychodynamic | clinical practice | no | pathology | personal | childhood |
| Phenomenological | clinical practice | no | pathology | personal | present day |
| Existential | clinical practice | yes | panhuman universal | human condition | life-long (permanent) |
| Sociological | social analysis | no | normative | society | history and the present day |
| Cognitive | research | no | normality | personal and situational | history and the present day |
| Personal | theory | no | normality | personal and situational | present day |
| Systemic | theory | yes | normality | personal and situational | present day |
| Interactional | clinical practice | no | normality | personal and situational | history and the present day |
| Biological | clinical practice/research | no | normality | genetic and situational | history and the present day |

Sources: (Perlman, Peplau 1982, p. 130; Weiss 1985a,b,c; Cacioppo, Patrick 2008) in: Kahan, Žiaková 2019 (adjusted by the authors)

The definition of *social loneliness* draws mainly from the interactional approach (Weiss 1985a, b, c), but it shares certain features with psychodynamic, Bowlby 1985; Weiss 1985b), phenomenological (Rogers 1973, in: Perlman, Peplau 1982; Rogers 1999; Hegel 2015; Maslow 2013; Ellis, MacLaren 2005), cognitive (Perlman, Peplau 1982; Kollárik 2008; Janoušek, Slaměník 2008), and sociological approach (Riesman, Glazer, Denney 2007). Therefore it is justified to consider loneliness a phenomenon that requires *metatheoretical thinking*.

*Loneliness due to 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 serious disruption of social roles and positions may cause a person to experience social isolation. A broad range of events can cause mental load, which are further enhanced by loneliness. In fact, everything that results in the loss of contact with people sharing the same interests can lead to loneliness due to social isolation. Therefore, the symptoms of social isolation can be observed in different groups, e.g. divorcees, unemployed, those who move to live in another place, but also in 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 orientation, persons suffering from psychiatric diseases) (Weiss 1985c; Kahan, Žiaková 2019).

Engagement in a peer group is almost or even equally important as the initial maternal bonding. Affiliation follows bonding and long-term absence of activities with peers causes anxiety as it does if bonding does not occur. Anxiety and suffering caused by loneliness due to social isolation in terms of which a person is excluded from group activities ensues very soon, and the pain grows over time. A lonely child waiting to join other children who merely watches them playing and mutters complains to the adults. When a person becomes adult, the issue of acceptance gains existential importance (Weiss 1985c). Sullivan (1953, in: Weiss 1985c) assumes that most of us have experienced the pain caused by being excluded by our peers in childhood. This bitter experience could be referred to as "fear of ostracisation". States related to social integration are different from initial bonding and these two cannot compensate each other. Children need to play with friends as well as they need their parents' care. Adults also need a social network that provides them with support and opportunities to engage, and also intimate bonding, which provides them with feelings of safety and love (Maslow 2013; Bowlby 1961; Weiss 1985c).

Weiss' (1985a,b,c) definition of loneliness refers to every individual's social and emotional worlds in which there is a broad range of situations that may lead to loneliness. The aforementioned dichotomous structure of loneliness can also incorporate different types of loneliness reflecting a person in the context of time and space. The following types of loneliness can therefore be specified:

a) *short-term* or *transient loneliness* – occasional lonely mood with short duration,
b) *situational loneliness* – caused by losing satisfying relationships due to a specific situation, e.g. divorce, moving. Situational loneliness can be very stressful, but does not necessarily be long-term,
c) *chronic loneliness* – caused by continuous absence of satisfying social relationships over two and more years. (Young 1982; Cacioppo, Patrick 2008).

From the psychological point of view, loneliness takes three forms:

a) *cognitive* loneliness manifests as the need to share one's ideas related to their professional or creative activity with another person who understands these,
b) *behavioural* loneliness can be described as the absence of friends with whom one can perform free-time activities and share the joy of doing so,
c) emotional loneliness occurs when the needs for love, intimacy, and security are not satisfied. This is the most extreme state of loneliness with most serious consequences, mainly if the sufferers are children (Žiaková 2008).

**4 Substance addiction**

The *bio-psycho-socio-spiritual* metatheoretical synthesis integrates the most relevant aspects that need to be taken into consideration in the context of addiction. The *bio-psycho-social* approach draws from the pharmacological model; it is based on the idea that the way psychoactive substances affect human body needs to be determined to select effective treatment. From the medical point of view, addiction is a health issue and in this context, the Alcoholics Anonymous perceive addiction as an incurable disease that can only be battled through one thing – life-long abstinence. Alcoholics Anonymous provide *social support* to other alcoholics and drug addicts who wish to overcome their addictions. The bio-psycho-social approach also takes into account the genetic determinants. Learning theories are often used effectively in therapeutic processes when clients are adopting new ways of behaviour. There is no universal treatment, some people need to rationally understand the internal, social, and physical stimuli that affect them personally, others achieve abstinence through understanding their own irrational patterns of behaviour through experiencing and emotional response (Ellis, Ellis 2013; Nešpor 2011; Volpicelli, Szalavitz 2000; Kudrle 2008; Vágnerová 2012). The journey to recovery and fully-fledged abstinence often requires searching for new sources of inner strength and a *sense*, which provides one's life with a *direction* and *purpose*. This approach built on three pillars is stable only as far as each of them is stable. Last but not least, *spirituality* represents the four pillar in treatment as well as abstinence, as it provides the opportunity for the person to find themself and identify their resources, which can help them to overcome addiction and accept responsibility for their life in abstinence. Jung (in: Nešpor 2011) claims that addiction may result from unfulfilled spiritual needs. Skála (in: Nociar 1991) describes addiction as a deformed form of human search for self, which Frankl (2009) further characterises as an escape from perceived meaninglessness in which the subjective experience of intoxication renders the person unable to capture the true meaning of their life. The existential vacuum with a

deep feeling of emptiness was diagnosed in almost 100% of drug and alcohol addicts. It indicates that the absence of life meaning, spiritual values and an authority represent the most significant risk factors in excessive use and abuse of addictive substances (Volpicelli, Szalavitz 2000; Křivohlavý 2006, 2010; Kudrle 2008).

Substance addiction and loneliness are multifactorial and conditioned psychosocial metatheoretical phenomena, which negatively affect the whole inner world of the addict and devalue their social and physical environments. Therefore, it is important to speak of social work competences in terms of theory integration in a way that allows for consistent research and safe, helpful work with the client.

**5 Research**

The aim of the research was to statistically determine how experiencing of social loneliness changes in substance-addicted people during treatment and its follow up in the context of abstinence, prevention, and lapse/relapse. Cognitive, behavioural and affective processes pertaining to loneliness were captured using respective measuring instruments, which reflect different dimensions of internal and external world of the person. Some of these instruments directly determined the level and type of loneliness, others can be characterised as reflective loneliness indicators, e.g. affiliation. In terms of this researches, substance addiction and abstinence was perceived as one of the constitutive and formative indicators that complete, enhance, and modify the level and type of loneliness. Scaling tools provide different ways to identify the presence and level of loneliness symptoms (Ferjenčík 2009; Hendl 2017a; Lovašová 2017; Ochrana 2013). Data from respondents were collected using a questionnaire battery. The selection of respondents was based on their willingness to cooperate, availability, and qualitative quotas (demography); the distribution was non-proportional. Using the IBM SPSS Statistics 20 program, descriptive, inferential, and exploratory statistics were created. Based on the analysis and collected data distribution, alternative correlation and causation tests were selected (Hendl 2009; Hendl 2017b, c; Campbell, Taylor, Mcglade 2017; Pallant 2007).

The questionnaire battery consisted of four independent tests and demographic data. The following tests were included:

1. UCLA Loneliness Scale (Version 3) is the third revised version of the loneliness measuring instrument (Russell 1996). UCLA is a one-dimensional construct which primarily evaluates the subjective feeling of loneliness due to social isolation. It identifies the general (overall) level of loneliness in accordance with the theoretical models of determinants and consequences of loneliness. The higher the score, the higher the rate of loneliness.
2. The T-98 Social Inclusion Questionnaire is a standardised diagnostic tool created by Kollárik (2008) designed for adult population; it diagnoses the need for social inclusion (NSI) among different groups that can be expected to experience difficulties with social inclusion. The questionnaire examines the motivational (desired social inclusion – DSI) and behavioural (achieved social inclusion – ASI) components of affiliation in terms of social inclusion. The social inclusion (SI) questionnaire consists of two theoretical SI concepts:

I. *Desired affiliation* (DSI)– represents the desired level of social inclusion determined by the intensity of the need; it is examined using the *need for social inclusion* (DSI) questionnaire. The part of the DSI questionnaire that examines the motivational level of affiliation consists of 30 questions with dichotomous answers (yes – no). The higher the score, the higher the need for social inclusion.

II. *Achieved affiliation* (ASI) – is the level and extent of social inclusion achieved; it is diagnosed based on the behavioural affiliation component. *This part of the SI questionnaire consists of 30 questions.* The higher the score, the higher the rate of social inclusion. Again, the answers are dichotomous. The results are interpreted based on the scores in individual questionnaire as well as the polarity of the differences between questionnaire values (Kollárik 2008).

3. *Manual of the loneliness scale*, OESL – Overal, Emotional, and Social Loneliness (De Jong Gierveld, Van Tilburg 1999). The test examines the level of emotional, social, and overall loneliness. Individual dimensions of loneliness can be processed together or separately. The lower the score, the higher the rate of loneliness. Questions are of conative, cognitive, and emotional nature.

**6 Research sample**

The total research sample N consisted of 235 addicted respondents. They were divided into two main subgroups: The hospitalised addicted respondents undergoing primary addiction treatment $N_H = 139$ and abstaining addicted respondents $N_A = 96$. The total research sample consisted of 160 males and 75 females aged 18–75; average age x=42.51, Med(x)=43. Tab. 2 shows the distribution of respondents based on their gender and basic diagnostic characteristics.

Tab. 2 Basic categorisation of respondents

| | $N_H$ 139 hospitalised respondents | | $N_A$ 96 abstaining respondents | | N 235 total number of respondents | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| males | 101 | 72.7 | 59 | 61.5 | 160 | 68.1 |
| females | 38 | 27.3 | 37 | 38.5 | 75 | 31.9 |
| substance addicted | 122 | 87.8 | 88 | 91.7 | 210 | 89.4 |
| non-substance addicted | 17 | 12.2 | 8 | 8.3 | 25 | 10.6 |
| substance and non-substance addicted | 4 | 2.9 | 5 | 5.2 | 9 | 3.8 |

**7 Social loneliness**

According to Weiss (1985c), social loneliness roots in childhood. Anxiety and suffering in result of social loneliness when a child is not accepted by the peer group and excluded from common activities is carried into adulthood; it determines whether the person is able to establish a social networks, make social contacts, and join certain social groups. Statistical processing did not confirm a difference between hospitalised and abstaining respondents in terms of experiencing social loneliness ($p(\alpha)$ 0,08), but the average values in Tab. 3 clearly show that hospitalised respondents experienced social loneliness more than their abstaining counterparts. Social loneliness may play a significant role in prevention of abstinence lapses. Based on this, it can be assumed that respondents who lapsed in their abstinence experience social loneliness in a statistically more significant way than those who retain abstinence (Tab. 5). However, it is obvious that respondents who do not undergo follow-up treatment are at higher risk of lapse/relapse. This risk seems to be higher in women, since statistically significant differences were found between hospitalised men and women in terms of experiencing loneliness due to social isolation (Tab. 6). On the other hand, no such difference was identified among the abstaining respondents (Tab. 7). Different rates of social loneliness in abstaining men and women were not expected, since all abstaining respondents were approached in self-help, socio-therapeutic, and psychotherapeutic groups. These groups saturate their need for safety, intimacy, and affiliation. To some extent, they can even saturate the need for intimate connection with another person, but these types of relationships must not be interchanged. The relationship between social loneliness and abstinence duration was statistically significant only in terms of the total abstinence duration with a weak correlation of $r_s = -0{,}291$ ($p_\alpha < 0{,}01$) (Tab. 4). The one-dimensional UCLA test identifies the overall level of loneliness, but it primarily focuses

on the subjective feeling of loneliness due to social isolation. The UCLA test identified a medium-strength relationship between loneliness and abstinence duration 0–12 months, and a weak relationship in terms of total abstinence duration. Based on individual calculations, it can be stated that social loneliness is related to abstinence duration, especially during the first 12 months; during this period, social loneliness represents a high risk factor of re/lapse (Tab. 4; Tab. 5).

Tab. 3 U-test – The rate of experiencing loneliness in substance-addicted people

| | | N | x(score) | x∑P | p(α) |
|---|---|---|---|---|---|
| UCLA | H | 122 | 46.32 | 122 | <0.001**** |
| | A | 88 | 40.48 | 82.3 | |
| SL Social loneliness | H | 122 | 16.81 | 98.8 | 0.08 |
| | A | 87 | 18.07 | 113.7 | |

**** $p_\alpha < 0.001$

Tab. 4 The correlation ($r_s$) between total abstinence duration and loneliness

| | | | Duration of abstinence (months) (substance + non-substance addicted) | | | Total duration of abstinence (substance -addicted) |
|---|---|---|---|---|---|---|
| | | | 0–12 | 13–36 | 36< | |
| Spearman's correlation coefficient ($r_s$) | UCLA | $r_s$ | **-,422*** | -,236 | -,141 | **-,265*** |
| | | p α | ,025 | ,228 | ,412 | 0.015 |
| | | N | 28 | 28 | 36 | 84 |
| | OESL social lonelines s | $r_s$ | ,331 | ,119 | -,058 | **,291**** |
| | | p α | ,086 | ,555 | ,738 | 0.008 |
| | | N | 28 | 27 | 36 | 83 |

** $p_\alpha < 0,01$; * $p_\alpha < 0,05$

Tab. 5 U-test – Lapse in relation to loneliness

| | abstinence broken | N | x(score) | x∑P | p(α) |
|---|---|---|---|---|---|
| UCLA | yes | 19 | 43.63 | 51.1 | 0.06 |
| | no | 64 | 39.41 | 39.3 | |
| SL Social loneliness | yes | 19 | 14.79 | 23.8 | <0.001**** |
| | no | 63 | 19.14 | 46.8 | |

**** $p_\alpha < 0.001$

Tab. 6 U-test – Difference between males and females in terms of experiencing loneliness (hospitalised)

| | gender | N | x(score) | x∑P | p(α) |
|---|---|---|---|---|---|
| UCLA | M | 84 | 44.5 | 54 | <0.001**** |
| | F | 38 | 50.34 | 78 | |
| SL Social loneliness | M | 84 | 17.68 | 67.4 | 0.006*** |
| | F | 38 | 14.89 | 48.5 | |

**** $p_\alpha < 0,001$; *** $p_\alpha < 0,01$

Tab. 7 U-test – Difference between males and females in terms of experiencing loneliness (abstaining)

| | gender | N | x(score) | x∑P | p(α) |
|---|---|---|---|---|---|
| UCLA | M | 51 | 40.25 | 44.8 | 0.882 |
| | F | 37 | 40.61 | 44 | |
| SL Social loneliness | M | 51 | 18.25 | 45.1 | 0.622 |
| | F | 36 | 17.81 | 42.4 | |

**8 Social inclusion**

The cognitive approach explains loneliness using two affiliation components: The motivational affiliation component is determined by the intensity of the need and the behavioural component represents the level of affiliation achieved. Optimally, these components should be balanced. A deviation either way indicates that the person may be feeling lonely or bothered by their social surroundings. The tests identified statistically significant differences between hospitalised and abstaining respondents in both affiliation components. Hospitalised respondents are less socially included (behavioural component), but also feel a more intense need to achieve inclusion (motivational component). It is the other way around in abstainers. Abstaining respondents are more socially included (behavioural component), which helps fulfil their need for affiliation, therefore their motivation decreases. It can be stated that in terms of cognitive approach and based on statistical calculations, hospitalised respondents are lonelier than abstainers. The average x-score values (Tab. 8) show that the differences between behavioural and motivational components in abstainers vs. hospitalised respondents are not significant, but the direction of this differences indicates that the hospitalised respondents may feel lonely.

Tab. 8 U-test – Social inclusion rate

| | | N | | x(score) | x∑P | p(α) |
|---|---|---|---|---|---|---|
| ASI | H | 114 | | 15.54 | 89 | <0.001**** |
| | A | 86 | | 19.12 | 115.7 | |
| DSI | H | 115 | | 17.59 | 110.1 | 0.016** |
| | A | 87 | | 15.93 | 90.2 | |
| ASI – DSI | H | 114 | 115 | | -2.05 | |
| ASI – DSI | A | 86 | 87 | | 3.19 | |

**** $p_\alpha < 0.001$; ** $p_\alpha < 0.025$

Since abstinence represents total restructuring of one's life, it is assumed that in abstaining respondents the motivational and behavioural affiliation rates will be relatively balanced. It is also justified to claim that besides saturating the need for affiliation, it is also important to balance its components; this way, individual need for social interactions will be taken into consideration, which allows the individual to feel comfortable and avoid disharmony.

**9 Discussions and research limits**

As for the limiting factors in this research, it was impossible to evaluate the differences between different substance-addiction diagnoses or compare the substance-addicted respondents with the non-substance-addicted ones. This resulted from the sizes of individual groups. However, it is assumed that individual groups of substance and non-substance addicted respondents differ in terms of loneliness experienced. It corresponds with Rokach's research (2002) who compared three groups of young adults – MDMA (methylenedioxymethamphetamine, ecstasy) users, users of drugs other than MDMA, and general population of young adults who do not use drugs. The research focused on personality and developmental deficiencies, dissatisfying intimate relationships, moving, separation, social exclusion from. It showed significant differences between all groups within all five factors. In a similar study, Orzeck a Rokach (2004) compared the multi-dimensional experience of loneliness in three groups: detoxifying opiate users, participants in a methadone substitution programme, and non-users. Certain differences were identified between individual groups, but the statistically significant differences in loneliness experienced were identified between detoxifying respondents and those who did not use drugs. The aforementioned studies have shown differences between psychoactive substance addicts, however, the main assumption of the presented research is as follows: the substance addicts experience various kinds of loneliness more than the abstainers regardless of the type of the addiction syndrome diagnosed. A more detailed analysis of loneliness experienced focusing on the individual substance addiction diagnoses may provide interesting results, however, it is not the goal of this research. Non-substance addictions, specifically behavioural Internet-related addictions represent a specific category (Young 1998; Patarák 2016; Patarák 2018). Significant differences may be shown mainly by the 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 other than physical relationships which may isolate them more; it can reflect in the total scores in some tests. Loneliness emerges as a by-product of excessive Internet use when the individual dedicates inordinately more time to the virtual

relationships than to the real ones; on the other hand, lonely individual use online activities to make contact with other users and communities through the Internet (Morahan-Martin 1999). Using the UCLA Loneliness (Version3), Morahan-Martin, Schumacher (2003) divided 277 university students into those lonely and not lonely. The lonely ones used the Internet to cope with anxiety, get emotional support, look for online friends, or modify negative mood 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 enhances as the addicted behaviour and negative internal experience develop. Substance and non-substance addictions have similar characteristics in terms of their development and symptoms across the individual diagnoses pertaining to the addiction syndrome. Despite their similarities, loneliness accompanying either of them has specific features.

Loneliness is very common experience, the youth and young adults are very familiar with it. This subjective experience is affected by personality, developmental history, life experience, and situational variables. Rokach (2005) studied how drug users undergoing treatment cope with loneliness. In his research, drug users were studies during their stay in detoxifying centres and compared to drug addicts undergoing the methadone treatment programme. These two groups were also compared to a group of young adults in general populations who did not use drugs. Aspects such as coping strategies, acceptance, reflection, self-development, understanding, using the social support network, distancing, refusal, religions and belief, increased engagement in social activities were studied. According to the results, these three groups of populations cope with loneliness in significantly different ways. However, statistical significance was confirmed in two strategies only: self-development/understanding and distancing/refusal. Self-development and understanding cover a group of loneliness (addiction)-managing techniques, which focus on self-reliance, self-care, revitalisation and growth – these are often learned in self-help and psychotherapeutical groups, as well as by accepting help and support from other professionals. Distancing and refusal, i.e. denial may be categorised as passive and negative coping mechanisms. In this research, this strategy include the following techniques: denying that something bad happened, withdrawing, building barriers around oneself, avoiding social interaction, and consuming alcohol. The respondents undergoing therapeutic programmes are purposely led towards self-development, understanding, and self-realisation, which helped them achieve better scores in using these strategies in loneliness management. On the other hand, distancing and refusal as strategies may have been learned in the long run during the drug abuse period, therefore drug users achieved higher statistically significant scores than general adult population. In our research, the activity in interpersonal interactions, adaptability, adaptation ability and speed in new situations as the behavioural affiliation component were examined using the T-98 Social Inclusion Questionnaire (ASI). The respective part of the ASI questionnaire proved that abstaining addicts achieve better scores in social interaction than hospitalised respondents with statistical significance. The abstainers in this research were recruited exclusively from groups that purposely focus on abstinence, therefore they were expected to be more socially included – as was the case in the aforementioned research. A prognostic study focused on a range of social, psychological, and medical variable including loneliness showed that it belongs among most significant negative predictors regarding the success of primary and follow-up treatment (Akerlind, Hornquist 1992). Despite these limitations, this research showed that abstaining addicts who re/lapsed feel lonelier than their successfully abstaining counterparts (Tab. 4, Tab. 5). Based on a comparison of our results with other studies, it can be stated that loneliness is a high lapse/relapse risk factor.

**10 Conclusion**

Addicted behaviour and loneliness result from a number of biological, mental, social, cultural, but also spiritual factors and it is desirable to perceive it through a holistic-atomistic lens – employ selected theories in main psychological directions, and use ecosystem metatheoretical thinking. Factors affecting the occurrence of addicted behaviour largely correspond with causes of loneliness and its types. These are mostly social and psychical factors, but it can be assumed that loneliness and addiction may share a common denominator on the biological level as well, e.g. increased sensitivity (vulnerable) of the organism to internal and external stimuli. The common social factors that can largely contribute to the emergence of addiction and cause loneliness include dysfunctional family, addiction in family, unsaturated need for social affiliation. Common psychical factors can be found in emotional experiencing, thinking, and behaviour. They include feelings such as inner restlessness, tension, anxiety, frustration, depression, overall dissatisfaction and emptiness. In the context of social interactions, difficulties coping with one's own emotional states can lead to avoiding certain social situations or negative coping mechanisms using drugs. Addicted behaviour and loneliness largely stem from irrational beliefs adopted by people during their lives. These irrational beliefs cause further issues, e.g. decreased self-respect and self-confidence, rigid thinking and behaviour, inappropriate patterns of behaviour, inability to respond flexibly to external stimuli, black and white absolutist thinking, denial and rationalisation of pathological behaviour, etc. The consequences of loneliness often overlap with those of addiction. It is related mainly to exclusion from certain social situations, decreased quality of social support and contacts, and general deterioration of life quality. Loneliness and addictions work together to deteriorate the psychosomatic and somatic health, in extreme cases they may lead to death. A metaanalysis of different approaches to loneliness and empirical studies shows both explicit and implicit correspondence with the etiology of addicted behaviour (Vágnerová 2012; Akerlind, Hornquist 1992; Rogers 1999; Langmeier, Matejček 2011; Perlman, Peplau 1982; Weiss 1985a,b,c).

**Literature:**

1. Akerlind, I., and J. O. Hornquist: Loneliness and Alcohol Abuse: A Review of Evidences of an Interplay. *Social Science & Medicine* [online]. 1992, 34(4) [cit. 2017-09-08]. ISSN 0277-9536/92. Accessible at: http://www.sciencedirect.com/science/article/pii/027795369290300F
2. Barth, F. D.: *Integrative Clinical Social Work Practice.* New York: Springer, 2014. ISBN 978-1-4939-0351-1.
3. Bates, M. J.: An Introduction to Metatheories, Theories, and Models. In: K. E. Fisher, S. Erdelez, and L. McKechnie, (Eds). *Theories of Information Behavior*. Medford, NJ: Information Today. 2005, pp. 1 – 24. ISBN 1-57387-230-X.
4. Blackburn, S.: *Oxford Dictionary of Philosophy.* 2nd ed. Oxford: Oxford University Press, 2008. ISBN 978-0-199541430.
5. Brenner, C.: On the nature development of affects: A unified theory. Psychoanalytic Quarterly. 1974, 43, pp. 635 – 654.
6. Bowlby, J.: Processes of Mourning. *International Journal of Psychoanalysis.* 1961, 62, pp. 317 – 340.
7. Bowlby, J.: Affectional Bonds. In: R. S. Weiss. *Loneliness: The Experience of Emotional and Social Isolation.* Cambridge: The MIT Press. 1985, pp. 38 – 52. ISBN 978-0-262-73041-9.
8. Bowman, C. C.: Loneliness and Social Change. *American Journal of Psychiatry*. 1955, 112, pp. 194 – 198.
9. Cacioppo, T. J., L. C. Hawkley, A. Kalil, M. E. Hughes, L. Waite, And R. A. Thisted: Happiness and the Invisible Threads of Social Connection. In: M. Eid, and R. J. Larsen, eds. *The Science of Well-Being* [online]. New York: Guilford. 2008, pp. 195 – 219 [cit. 2017-01-20]. ISBN-13 978-1-59385-581-9. Accessible at: http://psychology.uchicago.edu/people/faculty/cacioppo/jtcreprints/CacioppoHawkly2008.pdf

10. Cacioppo, J. T., and W. Patrick: Loneliness: Human Nature and the Need for Social Connection. New York: W. W. Norton & Co., 2008. ISBN 978-0-393-33528-6.
11. Campbell, A., B. J. Taylor, and A. Mcglade: Research Design in Social Work. Lndon: SAGE, 2017. ISSN 978-1-4462-7123-0.
12. De Jong Gierveld, J.: Developing and testing a model of loneliness. *Journal of Personality and Social Psychologis* [online]. 1987, 53(1), 119 – 128.[cit.2017-10-25]. Accessible at: https://www.ncbi.nlm.nih.gov/pubmed/3612484
13. De Jong Gierveld, J., and Van Tilburg, G. T.: *Manual of the loneliness scale* [online]. Amsterdam: VU University Amsterdam, Department of Social Research Methodology. 1999, [cit. 2017-10-20]. Accessible at: https://home.fsw.vu.nl/tg.van.tilburg/manual_loneliness_scale_1999.html
14. Dervin, B.: Sense-Makings Journey from Metatheory to Methodology to Method: an Example Using Information Seeking and use as Research Focus. In B. Dervin, L. Foreman-Wernet, and E. Lauterbach, (Eds.). *Sense-Making Methodology Reader: Selected Writings of Brenda Dervin.* Cresskill (NJ): Hampton Press. 2003, pp. 133 – 163.
15. Ellis, A., and D. J. Ellis: *Rational Emotive Behavior Therapy*. Wshington, DC: American Psychological Association, 2013. ISBN 978-1-4338-0961-3.
16. Ellis, A., and C. MacLaren: *Racionálně emoční behaviorální terapie*. Praha: Portál, 2005. ISBN 80-7178-947-X.
17. Ferjenčík, J.: *Základy štatistických metód v sociálnych vedách.* Košice: Univerzita Pavla Jozefa Šafárika, Fakulta verejnej správy, 2009. ISBN 978-80-7097-739-2.
18. Frankl, V. E.: *Psychoterapia pre laika.* Bratislava: LÚČ, 2009. ISBN 978-80-7114-690-2.
19. From-Reichmann , F.: Loneliness. *Psychiatry.* 1959, 22 (1), pp. 1 – 15.
20. Galvani, S.: *Supporting People with Alcohol and Drug Problems: Making a Difference.* Bristol: Policy Press, 2012. ISBN 978-1-84742-116-6.
21. Hegel, F. W. G.: *Fenomenológia ducha.* Bratislava: Kalligram, 2015. ISBN 978-80-8101-861-9.
22. Hendl, J.: *Přehled statistických metod: analýza a metaanalýza dat*. 3. přepracované vydání. Praha: Portál, 2009. ISBN 978-80-7367-482-3.
23. Hendl, J.: Měření. In: Hendl, J. a J. Remr. *Metody výzkumu a evaluace.* Praha: Portál, 2017a. s. 93 – 120. ISBN 978-80-262-1192-1.
24. Hendl, J.: Přehled metod sběru dat. In: Hendl, J. a J. Remr. *Metody výzkumu a evaluace.* Praha: Portál, 2017b. s. 81 – 92. ISBN 978-80-262-1192-1.
25. Hendl, J.: Metody analýzy dat. In: Hendl, J. a J. Remr. *Metody výzkumu a evaluace.* Praha: Portál, 2017c. s. 215 – 270. ISBN 978-80-262-1192-1.
26. Jandourek, J.: *Sociologický slovník.* Praha: Portál, 2007. ISBN 978-80-7367-269-0.
27. Janoušek, J. a I. Slaměník: Sociální motivace. In: J. Výrost a I. Slaměník, eds. *Sociální psychologie.* Praha: Grada, 2008. s. 147 – 159. ISBN 978-80-247-1428-8.
28. Kahan, J. a E. Žiaková: Stigmatizácia látkovo závislých ľudí ako významný rizikový faktor relapsu. In: L. Tóthová a K. Šiňanská, eds. *Sociálne riziká v spoločnosti XXI. Storočia. 7. ročník Košických dní sociálnej práce. Zborník príspevkov z vedeckej konferencie s medzinárodnou účasťou konanej dňa 30.11.2018 v Košiciach.* Košice: Katedra sociálnej práce Filozofickej fakulty UPJŠ Košice, 2019. s. 93 – 102. ISBN 978-80-8152-722-7.
29. Kollárik, T.: *Dotazník sociálnej začlenenosti - T-98.* Bratislava: Psychodiagnostika, a.s., 2008.
30. Křivohlavý, J.: *Psychologie zmysluplnosti existence*. Praha: Grada, 2006. ISBN 80-247-1370-5.
31. Křivohlavý, J.: *Mať pre čo žiť*. Bratislava: Karmelitánske nakladateľstvo, 2010. ISBN 978-80-89231-23-2.
32. Kudrle, S.: Bio-psycho-sociálně-spirituálni model závislosti jako východisko k primární, sekundární a terciární prevenci a kvalifikované pomoci. In K. Kalina a kol. *Základy klinické adiktologie.* Praha: Grada, 2008. s. 17 – 24. ISBN 978-80-247-1411-0.
33. Langmeier, J. a Z. Matejček. 2011. *Psychická deprivace v dětství*. 4. vyd. Praha: Karolinum, 2011. ISBN 978-8024619835.
34. Lawler, E. J., and R. Ford: Metatheory and Friendly Competition in Theory Growth: The Case of Power Processes in Bargaining. [Online]. In J. Berger, and M. Zelditch, Jr. (Eds.), *Theoretical research programs: Studies in the growth of theory.* Stanford, CA: Stanford University Press, 1993. pp. 172 – 210. Accessible at: http://digitalcommons.ilr.cornell.edu/articles/1195
35. Lovašová, S.: Konceptualizácia. In: B. Balogová a E. Žiaková, eds. *Vademecum sociálnej práce.* Košice: Filozofická fakulta Univerzity Pavla Jozefa Šafárika v Košiciach, 2017a. s. 340. ISBN 978-80-8152-483-7.
36. Ludewig, K.: *Základy systemické terapie.* Praha: Grada, 2011. ISBN 978-80-247-3521-4.
37. Maslow, H. A.: *A Theory of Human Motivation.* Mansfield Centre, CT: Martino Publishing, 2013. ISBN 978-1-61427-4377.
38. Morahan-Martin, J.: The Relationship Between Loneliness and Internet Use and Abuse. *CyberPsychology & Behavior* [online]. 1999. 2(5), 431 – 439 [cit. 2018-12-12]. Accessible at: https://www.ncbi.nlm.nih.gov/pubmed/19178216
39. Morahn-Martin, J., and P. Schumacher: Loneliness and Social Use of the Internet. *Computers in Human Behavior* [online]. 2003. 19(6), 659 – 671[cit. 2018-12-12]. Accessible at: https://www.sciencedirect.com/science/article/pii/S0747563203000402
40. Navrátil, P.: Sociální konstrukvizmus. In O. Matoušek a kol. *Encyklopedie sociální práce*. Praha: Portál, 2013a. s. 26 –31. ISBN 978-80-262-0366-7.
41. Navrátil, P.: Antiopresívni přístup. In O. Matoušek a kol. *Encyklopedie sociální práce*. Praha: Portál, 2013b. s. 92 – 96. ISBN 978-80-262-0366-7.
42. Nešpor, K.: *Návykové chování a závislost.* aktualizované. Praha: Portál, 2011. ISBN 978-80-7367-908-8.
43. Nociar, A.: *Alkohol a osobnosť*. Bratislava: Veda, 1991. ISBN 80-224-0281-8.
44. Ochrana, F.: Metodologie sociálních věd. Praha: Univerzita Karlova v Praze, Karolinum, 2013. ISBN 978-80-246-2380-1.
45. Orzeck, T., and A. Rokach: Men Who Abuse Drugs and Their Experience of Loneliness. *European Psychologist* [online]. 2004. 9(3), 163 – 169. [cit. 2019-03-15]. Accessible at: https://psycnet.apa.org/record/2004-18743-008
46. Pallant, J.: *SPSS – Survival Manual*. Maidenhead: Open University Press, 2007. ISBN-10:0-335-22366-4.
47. Patarák, M.: Patologické hráčstvo. *Alkoholizmus a drogové závislosti*, 2016. 51(2), 77–98. ISSN 0862-0350.
48. Patarák, M.: Kontroverzie okolo klasifikácie poruchy v dôsledku hrania počítačových hier. *Alkoholizmus a drogové závislosti*, 2018. 53(2), 67–79. ISSN 0862-0350.
49. Payne, M.: *Modern Social Work Theory*. 4th ed. Basingstoke: Palgrave MacMillan, 2014. ISBN 978-0-230-24960-8.
50. Perlman, D., And L. A. Peplau: Teoretical Approaches To Loneliness. In: L. A. Peplau, and D. Perlman, eds. *Loneliness: A Sourcebook of Current Theory, Research and Therapy* [online]. New York: Wiley, 1982. pp. 123 – 134 [cit. 2017-12-08]. Accessible at: http://www.peplaulab.ucla.edu/Peplau_Lab/Publications_files/Perlman_Peplau_82.pdf
51. Riesman, D., N. Glazer a R. Denney: *Osamělý dav.* Praha: Kalich, 2007. ISBN 978-80-7017-062-5.
52. Rogers, C. R.: Ellen West and Loneliness. *Review of Existential Psychology and Psychiatry*, 1961. **1**(2), pp. 94 – 101.
53. Rogers, C. R.: *Carl Rogers on Encounter Groups.* New York: Harper and Row 1973. ISBN 978-0060870454.
54. Rogers, C. R.: 1995. *Ako byť sám sebou*. Bratislava: Iris, 1995. ISBN 80-88778-02-6.
55. Rogers, C. R.: 1999. *Spôsob bytia.* Modra: Persona, 1999. ISBN 80-967832-0-3.
56. Rokach, A.: Determinants of Loneliness of Young Adult Drug Users. *The Journal of Psychology: Interdisciplinary and Applied* [online]. 2002. 136(6), 613 – 630 [cit. 2018-09-08]. Accessible at:http://dx.doi.org/10.1080/00223980209604823

57. Rokach, A.: Drug Withdrawal and Coping With Loneliness. *Social Indicators Research* [online]. 2005. 73(1), 71 – 85 [cit. 2019-04-15]. Accessible at: https://link.springer.com/article/10.1007%2Fs11205-004-2008-y
58. Russell, W. D.: UCLA Loneliness Scale (Version 3): Reliability, Validity, and Factor Strusture. *Journal of Personality Assessment* [online]. 1996. 66(1), 20 – 40 [cit.2017-12-12]. Accessible at: https://www.ncbi.nlm.nih.gov/pubmed/8576833
59. Slater, P.: *Pursuit of Loneliness.* 3rd. ed. Boston: Beacon Press, 1990. ISBN 978-0807042014.
60. Sullivan, H. S.: *The interpersonal theory of psychiatry*. New York: Norton, 1953. ISBN 978-0393001389.
61. Vágnerová, M.: *Psychopatologie pro pomáhajíci profese.* Praha: Portál, 2012. ISBN 978-80-262-0225-7.
62. Volpicelli, J., and M. Szalavitz: *Recovery Options: The Complete Guide - How You and Your Loved Ones Can Understand and Treat Alcohol and Other Drug Problems.* New York: John Wiley & Sons Inc., 2000. ISBN 0-471-34575-X.
63. Vakkari, P.: Information Seeking in Context: A Challenging Metatheory. In P. Vakkari, R. Savolainen, and B. Dervin, (Eds). *Information seeking in context: Proceedings of an international conference on research in information needs, seeking and use in different contexts; August 14 – 16, 1996, Tampere, Finland*. London: Taylor Graham, 1997. pp. 451 – 464.
64. Weiss, R. S.: The Study Of Loneliness. In: R. S. weiss. *Loneliness: The Experience of Emotional and Social Isolation.* Cambridge: The MIT Press, 1985a. pp. 7 – 30. ISBN 978-0-262-73041-9.
65. Weiss, R. S.: The Loneliness of Emotional Isolation. In: R. S. Weiss. *Loneliness: The Experience of Emotional and Social Isolation.* Cambridge: The MIT Press, 1985b. pp. 87 – 101. ISBN 978-0-262-73041-9.
66. Weiss, R. S.: The Loneliness of Social Isolation. In: R. S. Weiss. *Loneliness: The Experience of Emotional and Social Isolation.* Cambridge: The MIT Press, 1985c. pp. 143 – 154. ISBN 978-0-262-73041-9.
67. Wallis, S.: Toward a Science of Metatheory. [Online]. *Integral Review: A Transdiciplinary and Transcultural Journal for New Thought, Research, and Praxis*, 2010. 6(3), 73 – 120. Accessible at: https://ssrn.com/abstract=2322985
68. Young, J. E.: Loneliness, Depression and Cognitive Therapy: Theory and Application. In: L. A. Peplau, and D. Perlman, eds. *Loneliness: A Sourcebook of Current Theory, Research and Therapy.* New York: Wiley, 1982. pp. 1 – 18. ISBN 9780783728070.
69. Young, S. K.: Internet Addiction: The Emergence of a New Clinical Disorder. *CyberPsychology & Behavior* [online]. 1982. 1(3), 237 – 244. [cit. 2018-09-08]. Accessible at: https://www.liebertpub.com/doi/10.1089/cpb.1998.1.237
70. Zilboorg, C.: Loneliness. *Atlantic Monthly*, 1938. 161(1), 45 – 54.
71. Žiaková, E.: Teoretické vymedzenie pojmu osamelosti. In: E. Žiaková a kol. *Osamelosť ako sociálny a psychologický jav*. Prešov: Filozofická fakulta PU, 2008. s. 9 – 27. ISBN 978-80-8068-731.

**Primary Paper Section:** A

**Secondary Paper Section:** AN, AO, FL