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EDITORIAL

A call for better research and resources for understanding and combatting youth loneliness: integrating the perspectives of young people and researchers

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Loneliness is the overwhelming uncomfortable feeling of disconnect from others and can be experienced by individuals, even when they are not physically isolated. In recent years, there has been a lot of focus on loneliness in young people and the impact this has for longer term mental and physical health problems and healthcare and societal burden. The social restrictions brought about to control the infection rates of the COVID-19 pandemic have made even more evident the human need for interpersonal exchanges and interactions, and how the absence of social contact can unleash human suffering in the form of loneliness. Indeed, surveys by the Office for National Statistics in the UK showed an increase in individuals affected by loneliness compared to before the pandemic (from 5 to 7.2%), and these rises were magnified in areas where there were younger populations and higher unemployment. Some of the trends around young people being affected by loneliness were clear before the pandemic [3]. What was also clear pre-pandemic was the associations between loneliness and mental health in young people. There was a growing body of data indicating that loneliness in young people was linked, possibly trans-diagnostically, with persistent mental health problems, such as anxiety, depression, and eating disorders. There were also data to suggest that loneliness in young people could worsen outcomes associated with other neurodevelopmental or social communication problems. Yet, compared to research on loneliness in older adults, there has been a paucity of literature on understanding the mechanisms contributing to youth loneliness and, in turn, the development of interventions and programmes to help young people manage feelings of loneliness before they become associated with these mental health outcomes. This has prompted us—a mix of youth advisors (IA, EK, TP) and scientific researchers to write this editorial calling for better definitions of loneliness that in turn can inspire research into its development and maintenance, and amelioration. We argue for three points. First, there is a need to delineate chronic from transient loneliness. This will help identify those most at-risk for poorer health outcomes. Second, we argue that most resources available to support young people experiencing chronic forms of loneliness are not actually tailored to managing loneliness but instead treat loneliness as a side effect of other primary medical or psychiatric problems. Third, we discuss some of the barriers that some groups of young people—often those most at-risk for loneliness—may face in accessing support. We conclude by calling for researchers and policymakers to take note of these gaps in planning future studies and policies.

The need to define chronic loneliness

Loneliness is the subjective, uncomfortable experience of being isolated to others [1]. It is different from feeling alone, which can be beneficial. Being alone can provide young people with a sense of freedom from judgement [2] and a feeling of being able to make their own decisions, which in turn can develop personal autonomy. Being alone allows for honest self-reflection including around previous interpersonal interactions, which is important for young people to learn and grow. Working alone has also been shown to enhance performance on certain tasks and can boost creativity and encourage innovation [3]. Finally, relationships can benefit

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from aloneness, satisfying the age-old belief of "absence makes the heart grow fonder" [4].

But when does a positive sense of aloneness become a distressing feeling of loneliness? Loneliness can affect anyone, but young people, defined by the World Health Organization as ages 10 to 24 years, may be at greater risk. Data from the UK's Office of National Statistics (ONS) reported that, in 2018, 11.3% of young people aged 10–15 years said they were "often" lonely [5]. These data also showed adolescents and young adults aged 16–24 years to report feeling lonely more often than older adults [5]. Data from the COVID-19 pandemic also showed greater "lockdown" loneliness in young people [6]. Some groups of young people are at more risk for loneliness, for example, those from low-income and/or minority ethnicity families [7, 8]. Crucially, loneliness in young people is associated with stress, anxiety, low mood [9], and poorer mental and physical health, and can impact social relationships, academic performance, and other developmental outcomes [10].

Yet, even within the spectrum of loneliness experiences, there can be differences in their severity. For many young people, feelings of loneliness, even if they occur often, are temporary or situational. Scientific theories argue that these temporary feelings are adaptive [1]; they help people to navigate new social challenges at times of transition and help maintain a steady stream of social support. However, temporary loneliness can become persistent and require support. This form of loneliness has become known both in the academic and non-academic literature as "chronic" loneliness. However, there is no current definition of what chronic loneliness is and how it should be recognised. Private mental health services for adults describe chronic loneliness as: "constant and unrelenting feelings of being alone and isolated despite people being around you, difficulties in forming meaningful social connections, and feelings of exhaustion when trying to engage socially" [11]. Our own consultations with young people have identified chronic loneliness also in terms of persistence ("*Loneliness is this feeling you can't even properly describe in words fully but it's always present and extremely tough to shake*"), affective intensity ("*Feeling isolated, empty inside*") and effects on physiology ("*Sinking feeling in my chest, everything feels heavier.*").

Empirical research studies have tried to operationalise "chronic loneliness' more but across studies, these are homogenous and arbitrary, very often depending on which measures have been used and how many time-points have been used. For example, some studies [12] simply defined chronic loneliness as receiving a high score on loneliness questionnaires that assess loneliness items in terms of frequency (never to always). Other studies elaborate a bit more on this same definition but categorise those scoring one standard deviation above the mean as being chronically lonely—and those above the mean but less than one standard deviation as being "situationally" lonely—with both groups differing to those falling below the mean who are "non-lonely" [13]. For other studies with data across multiple time-points, these may capture chronic loneliness as those reporting frequent/persistent loneliness across two time-points [14]. Another group of studies, many involving adolescent samples from longitudinal cohorts, define chronic loneliness through statistical modelling procedures that identify different trajectories amongst participants (see [15] for a collection of such papers). These approaches usually identify a significant minority of participants (estimates range from 3 to 22%) who fall into the stable, high ("chronic") loneliness group. This group is often found to report more severe affective symptoms [16, 17] or factors linked with anxiety and depression e.g., low self-worth [18]. Despite heterogeneity across these different approaches, chronic loneliness variables are usually based on total scores on loneliness questionnaires that consider its frequency. Recently, a paper argued that "severe" loneliness needs to be thought of not just in terms of frequency of loneliness feelings, but also their duration and their intensity [19].

Reaching a definition of chronic loneliness also raises the question about whether this would medicalise a potential "normal" feeling of loneliness, particularly for young people. On the one hand, a medical lens on loneliness could bring more awareness to chronic loneliness and can motivate those who are experiencing such feelings to get help. On the other hand, for many individuals, feelings of loneliness will be temporary. Therefore, medicalising a universal emotional experience like loneliness has some disadvantages. First, putting normal experiences of loneliness or aloneness in a medical context may lead to potential stigmatisation of aloneness. This might encourage young people to avoid experiencing aloneness and any benefits it could offer. Instead, young people may try to make sure they are always with friends or family, which could introduce strain on the relationships and lead to isolation and loneliness. Second, an increase in people seeking medical help for normal emotions could also potentially strain the capacity of services, thus preventing those most in need of help from receiving it. This would also apply more pressure on organisations that provide these services as they will need to assess many people to determine who really requires the service. Additionally, these high numbers of referrals can cause long wait times which further impacts on young people's mental health.

Therefore, we argue that it is, on balance, important to make a clear distinction between harmful feelings of chronic loneliness that differ from "age-natural" feelings of temporary loneliness and beneficial experiences of aloneness. Research in this area—defining chronic loneliness and reaching appropriate cut-off scores on loneliness measures—should occur alongside public health, charity, or school-based campaigns to raise awareness and reduce stigma.

A need to develop more tailored resources for youth loneliness

The absence of a clear definition of chronic loneliness also makes it unclear when help should be sought and what type of support is most appropriate. Most evidence-based interventions targeting loneliness treat it as a side effect of another primary mental or even physical health problem [20]. For young people, these interventions usually include Cognitive Behavioural Therapy, but waiting lists in the UK are often long. An alternative to public services is to access private practitioners for mental health support. Based on our experiences, we believe that many young people and healthcare professionals see this path as more reliable without a long wait. However, they are limited by high costs and scarcity of services in some (particularly rural) locations. Another solution could be to access support facilitated through the voluntary sector. In many countries, there are charities which can link young people directly with counselling helplines or other forms of help (e.g., peer mentors); in the UK, this includes Barnardo's Listen and Link and ChildLine. Many of these resources are designed for young people with anxiety and/or depression, where loneliness is an additional feature. Nonetheless, they may help to alleviate temporary feelings of temporary loneliness by providing practical solutions (e.g., joining a social group), but may be less effective for those suffering from chronic loneliness. Finally, support for mental health in young people can be accessed through community groups or resources. However, while the basis of most social projects or youth groups is to bring together children with different issues, a few youth clubs are aimed at young people suffering from loneliness, with most being for specific groups: young carers, those from vulnerable homes, or those coping with bereavement. Although these can be very effective in supporting well-being and good mental health, there have been cuts to UK youth service funding by £1 billion between 2010 and 2019 [21]. A potential new avenue for accessing community-based care is through social prescribing, but the evidence-base for this remains unclear in general but for this age group in particular [22].

As loneliness is distinct from anxiety and depression—and is arguably precursory to these other emotional problems [9]—an investment into specific programmes to target loneliness is important. Where there are resources to target loneliness as a primary problem, most of these focus on loneliness in older adults rather than young adults.

A need to consider barriers to access to certain groups of young people

Even where general mental health support programmes can be accessed, there are additional barriers that some young people face. Some young people do not want their family to know about the issues they are struggling with, so they do not access help. There are also discrimination experiences, which may disproportionally impact the health of young people and their access to help. These include ableism, racism, and queerphobia/transphobia. Ableism can cover behaviours and systemic barriers which put disabled communities—both physical and psychological—at a disadvantage when accessing support through public and private channels. This can take the form of ableist language and stereotyping, which results in a lack of accessibility (written language, lack of online/virtual accommodations, lack of physical access) and disbelieving service users. Young people with disabilities face additional pressures such as negatively comparing themselves with peers, which can increase feelings of loneliness and magnify the impact of ableist barriers. Racism is another form of systemic barrier that prevents or hinders access to loneliness and mental health support. Systemic racism can include stereotyping of racial groups/young people from marginalised groups, lack of representation in mental health education, and also that young people from these families are often less able to afford the direct and indirect costs of accessing services. Queerphobia, including transphobia, refers to any barriers or discrimination preventing those within the LGBTQIA+ community from accessing support within the public or private sector. While queer representation in the media has improved recently, there are still internalised transphobic attitudes amongst medical professionals which impacts the quality of care and understanding of the needs of queer and transgender individuals, for example, experiencing microaggressions and discrimination from professionals [23, 24].

Increasing funding for loneliness interventions through clinical services, charities, or community groups is a priority to reach the young people most in need of support ideally before loneliness becomes more severe and linked with poorer health and well-being. Dedicated support workers providing intersectional support for specific age, gender, and ethnic demographics will help with the delivery of inclusive and accessible services specifically for loneliness.

Concluding remarks

Despite increasing public awareness of general mental health issues and the spotlight that the pandemic shone on youth loneliness, it is our personal experience that loneliness is an almost non-existent in public and private conversation. We need to build a better understanding of what chronic loneliness entails alongside social media campaigns and initiatives at schools to jump-start conversations about loneliness. More relatable information could be used as a foundation for campaigning for and developing additional avenues to support lonely young people. Further research into if and how being in a marginalised group may contribute to young peoples' loneliness and their experiences in seeking help would help professionals, but also society more generally, to identify these young people and tailor their care to be as effective as possible. Pursuing these research and dissemination paths would help to mitigate a loneliness crisis if we were to face a future pandemic where social restrictions are to be imposed.

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