Article

transcultural psychiatry

Transcultural Psychiatry
0(0) 1–15

DOI: 10.1177/1363461519880126
journals.sagepub.com/home/tps
SAGE

Loneliness, adolescence, and global mental health: *Soledad* and structural violence in Mexico

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Abstract

In this article, we call into question recent public health claims that loneliness is a problem of epidemic proportions. Current research on this topic is hindered by an overreliance on limited survey data and by paradigmatic imbalance that delineates the study of loneliness to psychological, cognitive, neuroendocrinological and immunological effects social functioning, physical health, mortality, and gene effects. The article emphasizes that scientific approaches to the phenomena of loneliness are more appropriately conceived and investigated as inherently matters for social, relational, cultural, and contextual analysis of subjective experience. Studies of loneliness and possible relationships to mental health status require investigations of social, environmental, and institutional structures as well as families, peers, friends, counselors, and health providers. This article takes a step in this direction through examining the lived experience of 35 high school students and their families living under conditions of social adversity in Tijuana, B.C., Mexico, with attention to anxiety and depression. Utilizing ethnographic interviews, observations, and psychological screening tools, we provide an overview for the group and illustrate the interrelations of subjective experience and social environment through a case study. These data reveal the vital role of understandings of loneliness, depression, and anxiety from the perspectives of adolescents themselves. We conclude that future studies of loneliness are best informed by in-depth data on subjective experience in relation to social features to advance understandings within the field of global mental health and allied fields.

Keywords

adolescents, depression, global mental health, loneliness, Mexico

> Fifteen-year old Marisol sits across the table in the empty classroom, her long dark hair covering the side of her face. Asked by the ethnographer to speak about what for her is a typical day, she recites her routine of going to school, where day in and out, friends are not to be found or appear distant. Returning home, she finds herself alone for hours until her parents return from work. When they do, her sense of feeling apart is not alleviated, as daily arguments between her parents pervade the household. Asked at the end of the first ethnographic interview if there was anything she wishes she could change or eliminate from her daily life, she thinks for a moment, and responds slowly, softly, with a single word: "*soledad*" (loneliness).

Recently, there has been a groundswell of attention to the problem of loneliness in association with mental health status. In this article, we make the case that investigations of this problem have thus far been limited by the absence of interdisciplinary approaches. This is the case for primarily two reasons. First, current research on this topic is hindered by an overreliance on limited survey data and by paradigmatic imbalance that delineates the study of loneliness to psychological, cognitive, neuroendocrinological and immunological effects, social functioning, physical health, mortality, and gene effects (Hawkley and Cacioppo, 2010). Second, current research has, notably and ironically, neglected the inherently social features within which loneliness is embedded; a key issue we address below.

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Addressing the imbalance in scientific approaches to the study of loneliness requires an interdisciplinary methodological approach to guide research that is grounded in: (1) the empirical study of the subjective experience of loneliness in real-world settings from multiple perspectives (persons, families, healthcare providers, teachers, community leaders); and (2) models of analysis that incorporate cultural processes and practices, social structural, political and economic arrangements – particularly as these affect populations and groups living under conditions of adversity that may compromise mental health and wellbeing.

To begin, we outline the recent groundswell of attention to loneliness and mental health. Next, we move to current research on the lived experience of adolescents and their families in relation to mental health in Tijuana, Mexico.[1] While not designed specifically to study loneliness, ethnographic observations and qualitative analysis of the interview materials revealed that loneliness was an important domain of subjectivity both broadly and specifically in relation to depression in the fieldsite. Following an overview of findings, we illustrate the relationship between loneliness and depression further through case study analysis.

Approaches to loneliness from public health and psychology

The upsurge of attention to loneliness is wide-ranging across the social, medical, public health sciences, government ministries, business enterprises, and prominent media outlets. Indeed, there are claims that loneliness is an imminent concern for global health (Yasamy, Dua, Harper, & Saxena, 2013; World Health Organization, 2017). Recent commentary on the ''growing problem of loneliness'' was published in *The Lancet*, with claims that approximately one-third of the population is affected (particularly among ''industrialized countries'') and that an appropriate response to the problem requires full engagement of the medical community (Cacioppo & Cacioppo, 2018, p. 426). Such suggestions have unsurprisingly been met with anthropological caution to ''beware the medicalization of loneliness'', particularly for a problem that entails social issues best investigated through multidisciplinary approaches (McLennan & Ulijaszek, 2018, p.1480). This is a reasonable caution with respect to the goals of understanding and empirically grounding the study of loneliness.

Currently available data on loneliness is primarily drawn from psychological survey instruments. On the basis of the widely utilized UCLA Loneliness Scale (Russell, 1996), a study of 20,000 US residents (Polack, 2018) found that nearly half of respondents feel alone (46%) or left out (47%). These data were received in many quarters as startling, as featured in prominent media outlets (Sifferlin, 2017; Fottrell, 2018; Chatterjee, 2018) and in the September 2017 issue of *Harvard Business Review*. The journal focused on negative impacts of loneliness in the workplace (Murthy, 2017). This discourse, presented as a threat to economic productivity, bears a striking similarity to corporate claims made nearly a decade ago with respect to depression as the ''perfect storm'' for undermining productivity in the workplace (Jenkins, 2010). Also featured in this issue is the perception of loneliness as a public health concern, which US Surgeon General Vivek Murthy (2017) labeled as a ''growing health epidemic''; further, he estimated that the effect of social isolation parallels ''a reduction in lifespan similar to that caused by 15 cigarettes a day''. Social isolation and loneliness must, however, be distinguished. Holt-Lunstad and colleagues (2015) define loneliness as a subjective emotional state that may involve dissonance of:

> ... dissatisfaction with the discrepancy between desired and actual social relationships (Peplau & Perlman, 1982)... social isolation and loneliness are not often significantly correlated (Coyle & Dugan 2012; Perissinotto & Covinsky, 2014) suggesting that these may be independent constructs and one may occur without the other'' (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015: 228).

Specification of subjective experience is therefore crucial to the definitions of social isolation and loneliness. Persons with little or no face-to-face contact with others are objectively at risk for a variety of poor health outcomes; indeed, the nine-country International Pilot Study of Schizophrenia (World Health Organization, 1979) found social isolation to be the *most* predictive factor for poor course of illness and outcome. The study by Holt-Lunstad et al. (2015: 227) found that ''overall, the influence of both objective and subjective social isolation on risk for mortality is comparable with well-established risk factors for mortality''. That said, the personal meanings of social withdrawal and loneliness require investigation of subjectivity, insofar as Corin (1990) found that persons with schizophrenia might utilize positive social withdrawal as a protective factor.

Loneliness as a public health issue of concern to nation-states is notable in the UK, Australia, the US, Canada, and India, with ambitious campaigns undertaken ''to end loneliness'' (Antrobus et al., 2014). While loneliness is generally acknowledged as afflicting persons across the lifespan, youth are identified as particularly prone to both loneliness and depression (Mushtaq, Shoib, Shah, & Mushtaq, 2014; Cavanaugh & Buehler, 2015) as are elderly populations in relation to poor

health (Wister et al., 2018). The UK has taken particular interest in the wake of a report that over nine million citizens in Britain often or always feel lonely (Kennedy & Reeves, 2017). This prompted Prime Minister Theresa May to take the unprecedented step (in January 2018) to create a Minister of Loneliness, appointing conservative Parliament member Tracey Crouch. The appointment took place amidst a charged political atmosphere surrounding the constriction of social, economic, and community services. The issue has cropped up elsewhere, including India, with the specific question ''Do we need a loneliness minister?'' raised in *The Times of India* (Devidayal, Das, Ghosh, & Dhawan, 2018) along with *The Indian Express* (Ali & Barnagarwala, 2018) seeking to reassure readers that: ''You are not the only one: India stares at a loneliness epidemic.''

Studies of loneliness and the life cycle have reported a relatively greater proportion of loneliness among adolescents and youths (Mushtaq et al., 2014; West, Kellner, R., & Moore-West, 1986; Anderson, 1999, Chen et al., 2004, Liu, Li, Purwono, Chen, & French, 2015, Stickley et al., 2016) while also noting a high prevalence for elderly populations, including sub-Saharan African countries (Phaswana-Mafuya & Peltzer, 2017; Nzabona, Ntozi, & Rutaremwa, 2016; Roos & Klopper, 2010; Waweru, Kabiru, Mbithi, & Some, 2003; Van Der Geest, 2004). Loneliness has been noted as commonplace among Nigerian and Japanese college students (Ishaku, Terao, Takai, Karuri, & Matsumoto, 2018). In Ghana and Chile, loneliness has been explored as a negative psychological health consequence of bullying and victimization in school settings (Owusu, Hart, Oliver, & Kang, 2011; Fleming & Jacobsen, 2009). In Mexico, government health websites only peripherally note loneliness as a public health concern in association with substance abuse or body piercings (Centros de Integración Juvenil, 2013; Secretaría de Salud, 2016).

Conceptual and comparative approaches of loneliness: An anthropological perspective

Conceptually, while anthropological questions surrounding loneliness are many, we identify specific issues as critical: (1) What *is* loneliness? How best to define and conceptualize it? Can loneliness be conceived as an emotion or as a disorder? (2) What are the descriptive characteristics of loneliness in relation to cultural, gendered, political, sexual, and aesthetic orientations? (3) What social settings and structural forces shape human loneliness? How might poverty, misogyny, racism, abuse and maltreatment, and political oppression foster loneliness? How might community milieu and familial psychodynamics moderate loneliness? (4) What are the biographical and cultural meanings of loneliness? Is the range of affects and meanings of loneliness comprised not only by dysphoria and despair, but also salubrious longing and desire? (5) Is there a significant link between loneliness and depression, anxiety, or other mental health ailments? While full consideration of these questions and their interrelations is not possible here, we explore conceptualizations of loneliness, and the subjective, cultural, structural, and familial shaping of loneliness, including attention to depression.

Anthropologically, the parameters for definitions of emotion have tended to be broad-ranging with attention to body and self in a particular sociological milieu (Rosaldo, 1984), and with culture and psyche understood as inseparable (Shweder & LeVine, 1984). Problems for the conceptualization of loneliness parallel those identified by Kleinman and Good (1985) for culture and depression. As for depression, can loneliness be conceptualized as an emotion, a disorder, or both? In approaching these questions, we favor an ethnographic approach that can flexibly traverse a continuum across realms of health and pathology (Du Bois, 1944; Levi-Strauss, 1962; Sullivan, 1964; Devereux, 1980; Canguilhem, 1991). For example, among Flathead Native Americans, O'Nell (2004) underscored the inseparability of depression and loneliness. Closer ethnographic attention to loneliness and mental health may bring such interrelations into clearer view (Ozawa-de Silva, 2008).

Comparatively, available transnational and cross-cultural data make it premature to declare loneliness as an emerging global health epidemic as claimed for the UK, Australia, and the US. While it is possible that the problem of loneliness is more significant than currently known, we currently lack evidence to support generalized claims for an epidemic of global proportions. We therefore propose caution regarding any epidemiological or public health rush to judgment; certainly findings from Europe, Australia, and the US cannot be presumed to hold for the majority of the human population. A parallel logic holds with respect to the possibility that loneliness has the potential to be associated with serious health matters; at present this is unknown in the absence of empirical validation. Generalized or universalist assumptions of loneliness are disconcerting given the absence of comparative psychological survey research in poor countries and regions, as is the implicit or explicit presumption that loneliness disproportionately afflicts ''industrialized'' (Cacioppo & Cacioppo, 2018) societies, or ''individualistic'' versus ''collectivist'' societies (Rokach, 2018). Hollan (1992: 283) called into question contrasts between ''Western'' and ''non-Western'' selves as

''very likely exaggerated because researchers often contrast simplified and idealized cultural conceptions of the self rather than comparing descriptive accounts of subjective experience''.

The question arises whether current attention to a perceived epidemic of loneliness from the perspectives of public health, psychology, and governmental ministries can be understood in part as a moral panic in relation to perceived changes in political, economic, and global forces. Such concerns might be shaped by ethnocentrism, racism, and global capitalism, wherein loneliness is presumed to be less of a problem in poorer countries or rural regions imagined as less existentially, culturally, and socially complex. However, troves of poetry, art, oral traditions, and cultural philosophies worldwide suggest that loneliness has been a problem across time and space rendering such attributions of comparative degrees of loneliness as dubious (Erdrich, 1988; Evans-Pritchard, 1937; Izquierdo, 1997; Neruda, 1974; Shostak, 1981). Drawing on parallels from past scholarship, suppositions associated with the ''modern/Western'' are dangerously reminiscent of racist assumptions applied to depression wherein ''Africans'', unlike Europeans, were presumed not to suffer from depression owing to a lesser capacity for moral emotions (guilt and shame). This racialist line of thinking was discredited decades ago with the landmark clinical-ethnographic study by M. J. Field (1960) documenting a rural Akan community as substantially affected by depression in ways not dissimilar to their European counterparts (Jenkins, 2018). The currently prevailing concern with loneliness as a public health crisis therefore raises questions about what such attention signals, silences, or brings to light.

This raises questions for how attention to loneliness can hold potential for awareness, recognition, and care, on the one hand, or possible misrecognition, obfuscation, and abandonment, on the other.

Mental health services, adolescent life, and loneliness in Tijuana, B.C., Mexico

Ethnographic studies of mental health services in Mexico have documented the need for (and scarcity of) mental health treatment in Mexico (Duncan, 2014, 2018; Foster-Reyes, 2018). To take culture more directly into account for psychiatric assessment and treatment, the DSM-5 Cultural Formulation Interview (CFI) was pilot tested in Mexican settings (Ramirez Stege & Yarris, 2017). While the CFI was observed to enhance patient-provider rapport, many of the questions concerning ''culture'' were judged as methodologically lacking in cultural validity. In a Mexican context, we would not expect that such be achieved in the absence of an understanding of the centrality of social and emotional attachments within the family (Carrasco & Lot, 2012).

Improving the capacity for culturally valid assessment is vital in Mexico since in recent years there have been reports of an increase in suicides, particularly among adolescents with approximately 11.5% experiencing suicide ideation (Benjet et al, 2018; Borges, Benjet, Medina-Mora, Orozco, & Nock, 2008). Drawing from a nationally representative sample of suicide attempts among Mexican youth, Valdez-Santiago and colleagues (2018) find Baja California as having some of the highest rates of adolescent attempted suicides in the country. The situation of Tijuanense youth therefore requires attention.

Over the past two years, we have conducted ethnographic fieldwork focusing on adolescent mental health at a high school in Tijuana, Baja California, Mexico. Our research explores the sociocultural, economic, and ecological contexts of subjective experience in daily life, with specific attention to emotional wellbeing. An overall aim of the study is to generate an ethnographically informed understanding of contexts and processes that shape the emotional wellbeing and mental health of adolescents. To do so, we are working not only with adolescents, but also their parents, teachers, and mental health providers to gain multiple perspectives on the subjectivity of key stakeholders in relation to cultural meanings and practices surrounding help-seeking for problems perceived in relation to mental health.

The high school and its surrounding zones in Tijuana where participants live are inhabited primarily by residents of low to low-middle income households; insecurity and economic precarity operate within the folds of daily life. The infrastructure of these sprawling neighborhoods is poorly constructed in comparison to more established and middle-class neighborhoods of Tijuana. Public resources are limited for residents, with unpaved sidewalks and roads and deficient public street lighting that make walking to school both difficult and dangerous, with limited police patrolling and community or recreational centers for inhabitants. These features have contributed to a precarious ecology of the neighborhoods, marked by the constant presence of violence in the form of robberies and homicides, as well as an increase of drug use and drug trafficking. In 2017, the second year of this study, Tijuana had just short of a two-fold increase from 910 homicides to 1,744 based on numbers reported by the Baja California Attorney General's Office (Dibble, 2018). Arredondo and colleagues (2018) provide extensive data by neighborhoods that highlight a marked resurgence of violent crime in Tijuana. This spike of insecurity is not widespread across Tijuana city zones, but is situated primarily in low-income neighborhoods, intensifying issues of insecurity in already precarious environments.

The struggles in participants' daily lives by virtue of their economic status further connects to a larger political and social discourse taking place in Mexico concerning wage labor. In recent years, reports have shown a gap between wages and work hours forcing many to work a substantial number of hours to make ends meet (Woody, 2015, 2017). In 2017, the minimum hourly wage was raised from about 80.04 pesos to 88.36 (approx. $4.25 to $4.70), though the economic benefits of such increase are not anticipated to make a difference any time soon (Fariza, 2017; Angulo, 2017). This economic and social context situates the experiences of loneliness among adolescents in our study.

Methods

Students from a large high school in Tijuana B.C., Mexico were recruited to participate in the study. The school serves students from surrounding neighborhoods of low and lower middle-income households. The research team emphasized that participation was entirely confidential and voluntary with no effect on their academic status. Students between the ages of 15-17 were recruited via flyers distributed around the school, and at parent-teacher assemblies (where the first and third authors were present and available to answer questions about the study). Participant recruitment also entailed snowball sampling insofar as some participants already enrolled in the study decided to recommend it to their friends or neighbors. We attempted to recruit as many individuals as possible, including students, parents, teachers, and service providers. This totals approximately 150 individuals. Because students were under the age of 18, parental consent was required before asking students whether or not they wished to participate in accord with approved human subjects protocol procedure of UCSD.[2] Parents who agreed to participate were then contacted via telephone calls to arrange times to meet to complete project procedures (described below). Teachers and school service providers were also invited to participate in group and individual meetings. Finally, healthcare providers in proximity to participant neighborhoods were also invited to participate.

Procedures

Our mixed-methods approach included use of sociodemographic forms, semi-structured interviews, focus groups, psychometric assessment scales, and on-site observations. At the beginning of each interview with adolescents and parents, we obtained basic background data such as gender, age, years of education, household composition, religious affiliation, and available healthcare resources. We conducted semi-structured qualitative interviews among each participant group and convened group focus meetings among teachers and parents. All student and school personnel interviews were conducted in an empty classroom at the school, while some parent interviews occurred either at the school or at their place of work. Mental health care provider interviews took place in their offices.

Interviews were completed for 35 adolescent participants (20 female, 15 male), 26 parents (20 female and six male), eight mental health care providers (seven psychologists, one psychiatrist), and two school service providers. We conducted up to four interviews with each student participant lasting approximately 30 minutes to one hour each. We conducted only two interviews with four students because we were able to cover all interview questions within that time frame. Parent, healthcare provider, and school service personnel interviews typically lasted between 45 minutes to one and a half hours. Interviews were conducted by three Spanish-speaking anthropologists of our research team trained in ethnographic observation and person-centered interviewing. All interviews were in Spanish, digitally recorded, and transcribed. No participants have withdrawn from this study.

In addition, we collected sociodemographic data, ethnographic observations, and psychological screening utilizing the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder (GAD-7) in Spanish for the adolescent participants as well as their parents. We employed the widely utilized PHQ-9 and GAD-7 instruments to gain an abbreviated clinical assessment of behaviors and moods that are typically utilized to determine whether fuller research diagnostic criteria might be met.

Analysis

NVIVO qualitative coding software and SPSS Statistics were used to analyze the interviews and observational data. Analysis of data from the focus groups has not yet been completed. We analyzed transcribed interviews via NVIVO, making use of its nodes and categories features to organize and analyze salient themes recurrent in interviews. We coded interviews based on a subset of nodes under emotional and mental health experiences such as anger, sadness, depression, sleep, stress, anxiety, loneliness and more. While our interviews explicitly asked questions about anxiety, depression, and nerves (*nervios*), we did not include questions about loneliness. Rather, in analyzing the coding reports concerning anger, depression, and sadness, we found that *soledad emerged* through the semi-structured ethnographic interviews despite the absence of any specific prompt for the experience of *soledad*. *Soledad* appeared as a frequent emotion often occurring in

conjunction with anger, depression, and sadness. Thus, we further coded for *soledad* as a node by searching for the word and its various conjugations, as well as by identifying experiences described in a similar manner without the explicit use of the word. A coding report was generated from this node and analyzed for thematic content. The sociodemographic data and PHQ-9 and GAD-7 scores were entered into SPSS for descriptive quantitative analysis that are the subject of a separate forthcoming article.

Overall findings for participants

From our data, we learned that socio-structural adversities permeate everyday familial and school contexts of participants. The surrounding neighborhoods of the high school where our participants live have high rates of violence and criminal activity; a reality prevalent in adolescent, parent, and school personnel interviews. This environment impacts adolescents' ability to spend time outside, make friends in their neighborhood, or leave their homes during the day as they are prohibited by their parents for their own safety. The school itself is surrounded by towering steel fences and is guarded by a security guard who collects visitors' identification cards in order to enter the school. Resources made available to students at this school include a counseling department where students can be referred to if a teacher identifies a problem, or students may seek this resource themselves. Within this setting, they may receive one-on-one assistance, though no clinical services are available.

Table 1 provides sociodemographic data (SDD) gathered from our Mexican student participants. As shown, 77% (n = 27) of students were born in Tijuana. While child and adolescent employment has surged in recent years in Mexico (INEGI, 2017b; Velázquez, 2018), about 11% (n = 4) of adolescents in our study are employed. The total household size ranges from two to nine persons with an average of approximately four persons in a household consistent with Mexican household demographics (INEGI, 2017a).

Table 2 provides SDD for our parent participants. As shown in the table, around 65% (n = 17) of parents were born outside of Tijuana. About 80.0% (n = 21) of parent participants are married or living with their significant others and the most common level of completed education for our sample of parent participants is middle school (30.8%, n = 8), followed by high school (26.9% n = 7) in accordance with broader Tijuanense sociodemographics (COPLADE, 2017) Catholicism is the most common religious affiliation among this sample, as it is for the broader Mexican population (INEGI, 2010).

Table 1. Sociodemographic data for Mexican student participants (N = 35).

Characteristics	n	%
Sex		
Female	20	57.1
Male	15	42.9
Age		
Mean (SD)	15.9 (0.7)	
Range	15–17	
Birthplace		
Tijuana, BC	27	77.1
Mexico (other states)	7	20
U.S.A. (CA)	1	2.9
Education (# of years)		
Mean (SD)	11.2 (0.6)	
Range	10–13	
Employment Status		
Employed	4	11.4
Unemployed	31	88.6
Total Persons in Household		
Mean (SD)	4.7 (1.2)	
Range	2–9	
Religion*		
None	6	18.2
Catholic	17	51.5
Evangelical Protestant	5	15.2
Non-Evangelical Protestant	1	3.0
Multiple religions	3	9.1
Agnostic	1	3.0

*Missing data (religion, N = 2)

In terms of familial routine life, it is common for both parents in the household to work in order to support their families, which is consistent with the approximate 2 persons employed per household in Mexico (INEGI, 2016). 48% (n = 16) of parents in the study work full time (25-48 hours a week) and 36% (n = 9) of parents work overtime (more than 48 hours a week). For this reason, not all parents could participate in the study due to limited time availability. This labor dynamic means that many of our adolescent participants spend considerable amounts of time alone at home or taking care of younger siblings and are simultaneously prohibited by their parents to go outside or leave the home.

While alone at home, adolescents often take on considerable responsibilities unsupervised such as caring for younger siblings, doing household chores, and cooking meals. Some are home alone for most of afternoons (and in some cases into the evenings) because both parents are at work. For others, being alone

Table 2. Sociodemographic data for Mexican parent participants (N = 26).

Characteristics	n	%
Sex		
Female	20	76.9
Male	6	23.1
Age		
Mean (SD)	42.6 (5.8)	
Range	33–59	
Birthplace		
Tijuana, BC	9	34.6
Mexico (other states)	17	65.4
Marital Status		
Married	17	65.4
Single	5	19.2
Living with significant other	4	15.4
Education		
Preschool & Primary School (1–7yrs)	4	15.4
Middle School (8–10yrs)	8	30.8
High School (11–13yrs)	7	26.9
University (14–18yrs)	6	23.1
Post Graduate School (18+ yrs)	1	3.8
Employment Status		
Unemployed	4	15.4
Employed	22	84.6
Hours Worked Per Week*		
Unemployed	4	16
Part-time (0-24 hr/wk)	0	0
Full-time (25-48 hr/wk)	12	48
Over full-time (48+ hr/wk)	9	36
Religion		
No religion	4	15.4
Catholic	19	73.1
Evangelical Protestant	2	7.7
Non-evangelical Protestant	1	3.8

*Missing data (hr/wk, n = 1).

may be sought after for the purpose of tranquility and peace in their homes. In fact, many students reported that in order to handle common emotional experiences of anger, sadness, and stress in their daily lives, they go to their rooms to listen to music, read, go online, or watch television until their emotion passes. For some, the desire to think, or process through their days, drives them to seek solace alone in their rooms. Based on the interview data, this is common practice. Also notable is that *being* alone in such instances does not necessarily translate into a subjective experience of *feeling* lonely. However, when subjectively perceived as *feeling* lonely, such experiences are often laced with sadness, absence, and anger, described as both distressing and painful.

Critical to those adolescents who experience *soledad* is the feeling of an *absence* of emotional connections understood by the adolescents as an absence of love and affection among family and friends. As our data show, *soledad* emerges within the context of fraught familial and peer relationships, not infrequently exacerbated by the frequent experience of being home alone for the entire day.

Feelings of *soledad*, as associated with the absence of these points of emotional connectivity, provide us with an understanding of "what is most at stake" (Kleinman, 2006) – in the subjectivity of daily life among these adolescents. Feeling precluded from the possibility of achieving culturally valued relationships of family and friendship in the context of a transitional period of adolescence contribute to feeling distance and discordance between the self and others (Burton, 1997). Implicated in the subjective experience of *soledad* is a "moral valuing" (Parish, 2014) by adolescents of their positioning within their interpersonal worlds, of what could be and what cultural values are possible to attain.

An anthropological examination of expressed emotion (EE) in familial and friend relationships reveals culturally constituted ideations of interpersonal relationships and their connection to mental health and illness (Jenkins, 2015; Karno, et al., 1987; Brown, Monck, Carstairs, & Wing, 1962). Cross-cultural studies of EE, which include criticism, hostility, emotional overinvolvement, warmth and positive comments within the emotional milieu of the family, have demonstrated the ways in which such emotional atmospheres influence wellbeing, as well as attitudes toward persons living with both psychiatric and non-psychiatric conditions (Jenkins, 2015; Jenkins & Karno, 1992; Blondin, Meilleur, Taddeo, & Frappier, 2019; Ellis, et al., 2014). This literature has illuminated the significance of cultural conceptions surrounding familial relationships and obligations. For Tijuanense adolescents, culturally defined deficiencies within familial and friendship relationships contribute to subjective experiences of *soledad,* and interconnections with feelings of anger, sadness, and depression become routinized in the experience of daily life.

Case study of Marisol: Dispirited, lonely, and depressed

An abbreviated example comes from Marisol, a 15-year-old girl in ninth grade. Based on our PHQ-9 data, Marisol scored a 15 on the scale, falling in the moderately severe category and a 14 on the GAD-7 scale, falling in the moderate category. We conducted three interviews with her over the course of two months. Marisol enjoys reading, listening to classical music, and drawing. She views Tijuana as a beautiful

colorida (colorful) city and oftentimes passes by the Plaza Revolución and Santa Cecilia to admire their beauty. Nonetheless she feels fear and insecurity going out alone because of the fear of ''being kidnapped, raped, or robbed''. She has a 12-year old younger brother who spends time after school at work with their mother, and a 20-year old sister has moved out and is expecting a child. Marisol's father, Ernesto, holds two jobs from which he does not return until 10 p.m. and her mother also works late, returning home by 9–10 p.m. Although Marisol's parents are separated, they continue to live together and frequent fights, tensions, and hostility toward one another at home are the norm. She laments that her sister, who she once felt she could trust (*confianza*) and talk to (*poder hablar*) now criticizes her and sides with her parents instead of Marisol. Ernesto, her father, came to his interview exhausted and irritable from working his two jobs as a tailor and caretaker for an elderly couple. He maintains both jobs to provide for his family and feels as though his work is his ''therapy''. Ernesto has suffered from ''*ataques de nervios*'' (nervous attacks) in the wake of a series of losses: his father died, his neighbor was killed, Marisol's godmother's son was murdered, and his truck was stolen, all within the span of two weeks. Despite all this, he needed to continue to work. He would like to spend more time with Marisol and recalls when they used to be able to go on walks together. He observes, however, that they no longer do so ''now since the killings started'' and that he ''prefers to avoid risking the safety of [his] children''.

He feels that his wife's constant accusations of his infidelity and her ''explosive character'' impact both his and Marisol's wellbeing. He admits that he ''always has to be on Marisol'' to get to places on time and to focus on her schoolwork. Ernesto expresses concern over Marisol's emotional state, though he ascertains that Marisol and her siblings attempt to ''manipulate'' [him], claiming that when Marisol ''doesn't get what she wants, she gets depressed''. This view casts doubt on the certainty with which Marisol's father regards her difficulties as matters of distress or depression. Instead it suggests he thinks due to her personal tendency to have her own way that depression could be a manipulative ploy on her part.

Marisol spends about 7–8 hours alone after school while her parents are working. During that stretch of time, Marisol does chores, completes her homework, reads, draws, and listens to music to pass the time. When we ask her how she felt about being home alone for most of the day she responds:

> To be honest, sometimes it makes me depressed [*me deprime*], because it's not like I have that closeness with my family. I mean it's like everyone is off on their own and that makes me feel . . . *desanimada* [dispirited, sad] and it makes me have . . . I don't know . . . like feelings of envy toward the rest of the people who I see are close with their families. During the day my mood varies. I can be happy while being alone [*al estar sola*] because I can be at peace and nobody will bother me. Other times, I can be lonely [*en soledad*] and melancholic for being completely alone.

Marisol describes a common lived experience among other adolescents in our study, which is that of being physically alone as a result of either self-isolation in their rooms or because they are the only ones at home while parents work. Her description of this experience shows that being physically alone does not necessarily mean that one feels lonely. Rather, in describing how she feels about being home alone she identifies a lack of closeness with her family as a situation that makes her feel ''*desanimada* (dispirited, sad)'' and envious toward other people whom she perceives as having more intimate and close relationships with their families. Not only is this feeling a result of her parents' physical absence during the day, but Marisol also reports a dissatisfaction with her parents' relationship stemming from frequent marital fights and arguments that she states have caused her to feel ''*deprimida* (depressed)''; an experience she defines as ''*absoluta soledad* (absolute loneliness)''. Marisol's narrations of the precarious environment in which the family lives shine a light on specific sources of *soledad* in Tijuana. For a low-income household defined by economic precarity, survival demands that the parents work long hour wage-labor jobs to provide for their three children. In Marisol's case her sense of loneliness is accompanied by moderately serious depressive experience.

Although at various times during the interviews, Marisol says she feels indifferent toward her lack of socializing or having friends at school, she nonetheless connected her lack of friendships at school with her three attempted suicides: twice by hanging and once by cutting. Marisol's parents sought help for her at her mother's behest when she noticed that her daughter's ''attitude had changed'', that she missed meals, her grades were faltering, and she was harming herself. Since Marisol would not tell her what was wrong, her mother decided to take her to a psychologist. While in treatment, Marisol reached a point where she felt that the sessions were no longer helping, primarily because nothing was changing at home.

In Marisol's case, the determination of when and whether to seek treatment is dynamic (for her mother and herself) in relation to distress and desperation. Regarding social stigma, Marisol is aware of the perception among some of her peers that a psychologist is for ''locos'' (''crazies''), a view with which she does not

agree. For her, it was a matter of the experience of substantial distress, which she judged her peers would likewise seek help, if they felt that they needed it. Her willingness to see and interest in returning to see a psychotherapist illustrates the value of person-centered ethnographic research. Through this approach, we are able to move beyond familiar popular and public health claims about social stigma of mental illness in Mexico that draw primarily from every day public discourse or from primary healthcare settings wherein social stigma is thought to be a barrier to seeking treatment for mental health conditions (Galván, Saavedra, Bartolo, & Berenzon, 2017). When ethnographic research in Mexico is undertaken at a closer level of investigation, a different picture emerges, such as that identified by Whitney Duncan (2014, 2018). Through her research with patients and families, Duncan found people who seek help for mental illness at public hospitals to be remarkably determined, resourceful, and less concerned with social stigma than actively pursuing available services. Investigation of social stigma surrounding mental illness should, therefore, be nuanced with respect to discriminatory stereotypes that may more easily be deployed at a social remove, on the one hand, and first-person and kin-related experiences, on the other (Jenkins & Carpenter-Song, 2008, 2009). Close proximity and experience/near familiarity with such conditions that are shaped by affinity (versus alterity), may lead to active care-seeking wherein while social stigma hardly disappears or is neutralized, it is outweighed by the pressing need to seek care.

Psychological and emotional development: Painful continuities and discontinuities of elementary and middle school

Adolescence has been addressed by psychological theorists and anthropologists (Mead, 1928; Sullivan, 1968; Schlegel, 1995; Adams, 2005). In his influential volume *The Interpersonal Theory of Psychiatry*, Sullivan suggests that the juvenile years are marked by the necessity for intimacy and acceptance among peers to procure security. Indeed, belonging and inclusion among peers during adolescence has been a focus in developmental psychology as an explanation for feelings of loneliness. These processes may, in some sociocultural contexts, entail social acceptance and connection with peers as most salient. Such is certainly the case in the present ethnographic case for Tijuanese adolescents, where lack of friends at school or bullying may potentially conduce to feelings of depression, isolation, and loneliness (Lasgaard, Goossens, & Elkli, 2011; Heinrich & Gullone, 2006; Asher & Paquette, 2003; Larson, 1999). In turn, anthropological analysis of adolescence has been examined as a period constitutive of possibilities for identity-making and cultural and social integration (Csordas & Jenkins, 2018; Burton, 1997). The developmental continuity between periods defined as childhood and adolescents (which are culturally and historically variable) is not, however, distinct. Indeed, many of the adolescents in our study who reported being bullied in middle school had similar problems in elementary school. This required taking a longer developmental view to understand the pathways that conduce to emotional and mental health states among teens.

Summary remarks and future directions

There are several key points we have emphasized in this article. First, we have identified key anthropological questions that entail conceptualizing loneliness broadly and specifically as a human phenomenon. As for other dimensions of subjectivity, such as the self, emotion, and identity (Jenkins, 2004), we theorize loneliness as a fundamental capacity for all humans in relation to the innate and cultural sociality of being human. While loneliness among humans can be banal and in that sense pervasive, care must be taken to recognize that in some cases (as described herein in the case study among adolescents), such states can be experienced with an intensity and severity so that loneliness becomes suffused with moderate or severe degrees of depression, anxiety, and suicide attempts, among other mental health-related conditions.[3] The findings obtained here are therefore of relevance to an understanding of the interrelations of adolescent depression, isolation, and loneliness. They also speak to the need for a broader theoretical understanding of the interrelation between social context and subjective experience, made possible only through attention to the social environment in tandem with experience from multiple perspectives of family, peers, and youth.

Second, on the basis of our observations from research in Mexico, we are convinced that the study of loneliness can be enriched by broadening the scope of enquiry to incorporate ethnographic study. These methods provide the foundation for seeking insight into the intricacies of personal, cultural, and political dimensions of loneliness, particularly with respect to the well-being of youth living under conditions of structural violence and precarity. Our research also provides the empirical grounds for proceeding with specific investigation of loneliness, particularly in relation to depression, as part of the research agenda for the burgeoning field of global mental health (Becker & Kleinman, 2013; Patel & Saxena, 2014; Kirmayer & Pedersen, 2014; Kohrt & Mendenhall, 2015; Jenkins & Kozelka, 2017).

A productive approach toward this goal would be to first establish ethnographically what the ethnopsychological and cultural parameters for loneliness may be (as carried out in the present research). The ensuing consideration would be whether attention to loneliness may establish if the problem is of clinical relevance for service providers in carrying out assessments and intervention planning. Our overall findings, along with the case study presented, point to an experiential connection between loneliness and depression.

Third, while this study provides no evidence to support the notion of an "epidemic" of loneliness in relation to depression, it illustrates a significant (over one-third) proportion of adolescents who experience loneliness as part of their depression in a non-clinical community setting. It is not possible to know pathways but we hypothesize a reciprocal set of relations among loneliness and depression. As a matter of mental health it is important to attend to these interrelations, including the role of social stigma with which these are associated (as illustrated in the case study). The results also point to the critical need to attend to structural forces as exemplified by the heavy toll of the parents' workloads in the context of trying to make ends meet. Likewise, the profound influence of poverty requires far greater attention as such conditions disproportionately affect women (Patel, 2005). Also among adolescent populations (including the case study) is the increasing commonality of the practice of self-cutting, particularly among girls, as a "cultural and experiential locus of a crisis of agency in the relation between body and world and thus as the enactment of a fundamental human process in the context of individual experience" (Csordas & Jenkins 2018: 206).

Fourth, we note that going forth there is a need for multidisciplinary methods beyond currently employed psychological survey methods that take the primacy of lived experience as the starting point and ethnographic approaches as foundational for research on the subject of loneliness, and global mental health research more broadly. For loneliness specifically, there has thus far been an overreliance on the UCLA Loneliness Scale (Russell, 1996) as the 'gold standard' in global research. Despite the establishment of reliability and factor structure in accord with psychological research standards, we identify several conceptual limitations of this scale, to include overreliance on individual, personality-based items ("friendly/shy") and associations of loneliness necessarily in the absence of shared ideas, interests, and social connections. The absence of shared ideas/interests/connections in social settings might presume personal control over one's social settings (familial, work, school, community) in which any given set of normative expectations and political orientations are in play. If a person does not feel "in tune" with people, for example, it may be related to a variety of factors such as a sense of political, sexual, ethnic/racial, and gender difference at odds with one's everyday settings; moreover, subjective feelings of being "apart" may in certain settings be conscious acts of dissent, divergence, and meaning that are not necessarily matters of loneliness. Thus, individual psychologically-based factors, when assessed in the absence of specific contexts of cultural, social, and political subjectivities in which people live, work, participate (or are excluded), requires great attention to how subjectivities may be consonant or dissonant given any prevailing ethos, normative expectation, or possibility for agency. Ethnographic research on loneliness with attention to lived experience can provide a foundation for better understanding of the range and types of loneliness that cannot be ascertained through epidemiological or survey data. On the basis of our research, we are convinced that it is necessary to pay attention to the perspectives of adolescents themselves (James, 2007).

Finally, we note that while loneliness may be experienced across the full range of developmental stages, research is needed to contextualize the experience of loneliness across the lifespan. Such specification must consider socioeconomic and political circumstances, gendered and sexual identities, psychodynamic and attachments within families, along with social relations within communities and among friends. In this article, we have identified anthropological questions surrounding loneliness. We identify several issues as primary with fundamental questions regarding conceptualization of and descriptive characteristics of loneliness in relation to cultural, gendered, sexual, political orientations, social settings and structural forces of adversity. There is also a critical need to attend to structural forces and gendered contexts in relation to the devaluation of girls and women that will require further attention in studies of loneliness and global mental health broadly (Afifi, 2007; Jenkins & DelVecchio Good, 2014), and in low-income countries and regions in particular (Desjarlais, Eisenberg, Good & Kleinman, 1995). Fleshing these questions out will require study of loneliness that takes into consideration the subjective, cultural, structural, and familial shaping of loneliness to include depression and other mental health concerns. In our view, loneliness cannot be reduced to social epidemic or byproduct of medicalization because such formulations do not address the reality of loneliness as lived experience – whether ordinary or extraordinary – across a diversity of lives and settings. The larger question concerns what an understanding of the range and types of loneliness can teach us about what it means to be human. Loneliness, as a vital, intricate, and intimate emotional realm requires breadth and depth of understanding.

Acknowledgments

The authors wish to acknowledge appreciation of contributions by other members of our UCSD research team and collaborators who supported this work, including Alma Casillas, Thomas Csordas, Ph.D., Sol D'Urso, M.A., Ellen E. Kozelka, C.Phil., and Alexandra Pryor, B.S., B.A. We appreciate the support of Olga Odgers, Ph.D. and Ietza Boroquez, Ph.D. of the Colegio de la Frontera Norte, Tijuana, B.C., Mexico. Finally, we express appreciation to the students, teachers, counselors, and parents who participated in this study.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: We are grateful for funding awarded to the first author as Principal Investigator for research through the Frontiers of Innovation Scholars Program at the University of California, San Diego, as well as the Academic Senate.

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Notes

1. The first author is Principal Investigator for the study reported upon here, "Cultural Perceptions of *Bienestar Emocional*" (Emotional Well-Being) and Patterns of Help Seeking: An Anthropological Study in Tijuana, Mexico. All of the authors were involved with data collection for parents, students, and providers, with Dr. Olivas taking primary responsibility.
2. Research was carried out in accordance with approved procedures for human subjects protection UCSD IRB protocol #160163S. All names are pseudonyms.
3. We wish to express gratitude to three anonymous reviewers whose detailed comments and suggestions have served to improve this article.

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