BRIEF 3 – BREAKING DOWN ISOLATION

BROAD CONCEPTS

The concept of 'mental health' early on allied itself with a medical model of illness. So, it came to have a 'diagnosis' approach, identifying conditions to be cured. The hope was that with a cure the person would then just resume a normal lifestyle and continue as they were before.

Just as this didn't always work with medical procedures, it didn't always work well with mental health conditions. In fact, probably not as well. People have memories and emotions, and the associations that go with them. With conditions as intangible as mental states things tend to linger.

While recognising, differentiating, and defining mental states has been extremely beneficial, it needs to be remembered these conditions are the 'What', not the 'So, what'.

Now it is in the nature of any illness, bodily or mental, to force people to focus on themselves, find a safe place, accept restrictions, and isolate themselves. Short term, this is for their good. If the tendency continues, it becomes an issue in itself.

Very often it also results in people profoundly changing their view of themselves, e.g. they are now vulnerable, weaker, blemished.

THE ISSUE OF ISOLATION/LONELINESS

There are many ways of describing isolation or loneliness in the English language. I suspect that there are as many in most other languages. We are a social species. We don't do so well when we are isolated. So, just about all of the words have negative associations.

What follows from isolation is the great lessening in opportunities for stimulation. This is a serious restriction as it is contrary to a basic feature of brain function – the capacity for association. This capacity applies almost universally. Behavioural skills that are similar to those already mastered are learnt more quickly. As are ideas and languages. Being reminded and putting together novel combinations allowing

inventive thoughts and behaviours are all aspects of the capacity of association. And emotion attaches firmly to all of these.

The consequences of isolation include:

- Worsening mental health - conditions such as depression and anxiety flourish in isolation.
- Increases the likelihood of mortality - this is more than just suicidality.
- Increased risk of poor long-term personal health.
- Unwanted events have an increased effect.
- Loss of a capacity for enduring friendships.
- Watchfulness and increased social caution.
- Loneliness and isolation are 'contagious' in that those with whom they do associate are more likely to also act in in the way described.

This has reached the point where loneliness and isolation are being considered as the next major public health issue. The United Kingdom and Canada have already set up a Minister for Loneliness and Germany is considering appointing a Commissioner for Loneliness.

Ironically, social media is generally seen as something that overall increases the chances of social isolation by it's tendency to simulate interaction rather than provide full interaction. It lacks the array of co-occurring interpersonal cues that make up face-to-face interactions.

SOURCES OF THE EXPERIENCE OF ISOLATION/LONELINESS

Isolation arising from a health condition is only one source of this experience. Other sources include being

- Elderly.
- Handicapped.
- Disadvantaged.
- Bereaved.
- Separated – relationship breakdown or just distance.
- Newly arrived migrants.
- Released prisoners.
- Ex-service personnel.
- International students.
- Unemployed persons.
- New parents.
- Personal resources deprived

It then follows that not being isolated increases the chances of enrichment and satisfaction, and friendship formation. The breaking down of isolation is not just about increasing involvement in community groups. The key factor seems to be the acquiring of enduring quality relationships, particularly that of friendships. These take time to acquire. To borrow from the fairy tale – a lot of frogs usually need to be kissed.

Isolation and loneliness are emotional states and need to be regarded as such. They need to be seen as different in nature and tone from other related emotions such as solitude. A key difference is whether choice is being exercised.

THE CHALLENGE OF THIS BRIEF

The key to this brief is to concentrate not on the clinical issues of mental health – the 'What' – but on on the 'So What'. As in 'So what can be done', e.g. to foster factors such as trust, reassurance, comfort, satisfaction, company, interest, predictability, patience, consistency, humour and the like that go into the experience of this thing called Friendship.

The opportunity is to consider how it appears in any of the different groups listed (or any others in which you consider loneliness to be an issue) and the differences in how it could be best addressed.

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