Isolation and mental health: thinking outside the box

Vanessa Brown,[1] Tezonia Morgan,[2] Andrew Fralick[3]

[1]Department of Clinical Psychology, Michigan School of Psychology, Farmington Hills, Michigan, USA
[2]Wings of Virtue Counseling and Research Institute, Southfield, Michigan, USA
[3]Ascension Eastwood Behavioral Health, Ascension Michigan, Livonia, Michigan, USA

Correspondence to
Andrew Fralick;
drewfralick@gmail.com

Social isolation is a universal human experience, impacting whole communities at times and reminding each individual of our need for connection. Isolation weaves through life on an intrapersonal, interpersonal and existential level; all individuals experience this phenomenon, to varying degrees, at points in their development. Research has shown that persistent social isolation is a predictor for cardiovascular problems, mental health disorders and increased mortality rates.[1] Therefore, it is crucial for healthcare professionals to understand the various forms in which isolation can manifest and ways to foster meaning as a protective factor. As mental health professionals, we must grow in our understanding and willingness to imagine novel solutions for persistent isolation that aid the long-term health of individuals.

Individuals who live alone, those who are abused, those who lack a healthy support system and members of marginalised groups are prime candidates to suffer from depression and anxiety.[2] For these individuals, being isolated can be both tormenting and a relief. Isolation is a result of anxiety and depression in that some individuals use it as a self-induced coping mechanism to deal with excessive worry and avoid human interaction. For others, isolation is a key driver of anxiety and depression, craving the support and stimulation that socialisation provides.[1] Organisations, such as Mental Health America, represent the need to address mental health by dedicating several pages on their websites to detailed information and resources.[3] Most of these websites emphasise a need for social interaction by providing links to therapists in the surrounding areas, listings of groups and even specifically recommending that individuals 'connect with others'. The mental health field employs techniques that help clients change patterns of isolation.[4] However, factors have shifted, and remedies need to be re-evaluated. It is evident that society is feeling the effects of being quarantined and mental health therapists are seeing it first-hand. We are beginning to acknowledge that isolation is inescapable for some individuals, yet we lack the training to help individuals adapt to these circumstances.

There are several theories that assist in alleviating symptoms of both depression and anxiety as they relate to isolation. Cognitive behavioural therapy, behavioural therapy and rational emotive behavioural therapy are examples of evidence-based therapies used to treat the negative impact of isolation. These therapies include interventions such as learning and implementing problem solving strategies, engaging in pleasant activities outside of the home, maintaining involvement in social activities and other behavioural interventions geared towards improving mood and reducing anxiety. Unfortunately, these treatment modalities provide little guidance to treating negative emotional reactions to persistent isolation because the catalyst of pain is still active. This phenomenon is paralleled by how some minority groups are unable to successfully complete therapy because the locus of control or external forces are still active in their lives.[5] The authors of this study revealed that until the external forces that contribute to anxiety and depressive symptoms are addressed, marginalised populations will continue to suffer from depression and anxiety. Research by Ahmed and Conway supports the notion that external stress must be addressed before symptoms of depression and anxiety are tackled.[6] Currently, many therapists are using crisis-based techniques to stabilise clients, which include suicidal assessments, referrals to agencies that can supply the immediate need or brief solution-focused sessions. Crisis-based techniques serve as triage stabilisation until the client can be seen on a regular basis. Yet, anxiety and depression remain as isolation becomes unavoidable for some. It is readily observable that anxiety and depression are being experienced on a collective scale as a reaction to isolation, in

which people live dislocated from: (a) other communities; (b) their own community; and (c) that which gives life meaning. Mental healthcare should address these forms of isolation from an approach that does not require control over external forces.

Humanistic-existential theorists have long addressed isolation as one of the existential givens (death, isolation, freedom and meaninglessness).[7] Yalom outlined three types of isolation: existential, intrapersonal and interpersonal isolation.[8] Existential isolation encapsulates the pervasive innate sense of disconnection between one's self and the world. Humans hold an internal world that is private and necessary to survival. Therefore, some level of isolation is always experienced and is unavoidable. Even more alarming is the realisation that our time in this body is limited and that we will die; as will everyone we love. Most often, one is unaware of existential isolation or death anxiety owing to allocating cognitive resources to achieve a purpose, such as working or raising a family.[9] Awareness of existential isolation is triggered with catastrophe, loss and other major changes that highlight isolation. In the realisation of imminent loss of existence (death) and the separation it entails, the fallibility of humanness sets in. Death comes at any moment, loss is inevitable and there is a lack of whole connection. Within this sense of isolation exists an opportunity to reassess one's life, to reflect on relationships and to make a choice regarding how to proceed. Yet, the opportunity for meaning-making and growth competes with a frantic need to avoid the discomfort of existential isolation.

As a means of avoiding despair-related to existential isolation, defence mechanisms serve to cut off emotion from cognition in order to avoid distress and despair. This form of intrapersonal isolation creates separation between parts of self. As Yalom writes, 'intrapersonal isolation results whenever one stifles one's own feelings or… distrust's one's own judgement, or buries one's own potential'.[8] This is typically the stage in which an individual might seek out mental health services. Most depth psychologies, such as Gestalt, interpersonal, humanistic-existential and psychodynamic theories emphasise a return to psychological wholeness. One path towards wholeness exists in connecting with others. If isolation is inevitable because at the root of humanness is the loneliness of existence, then there is also connection through universal solitude. We all die and share a universal anxiety about death; we all also strive towards life and purpose. Buber wrote, 'A great relationship… breaches the barriers of a lofty isolation, subdues its strict law and throws a bridge from self-being to self-being across the abyss of dread of the universe'[10], thus love serves a protective function within isolation.[8]

Interpersonal isolation is the disconnect with others that most often leads to loneliness.[8] It is important to note that a sense of interpersonal isolation, or

loneliness, can occur even if others are physically present. Matthews and colleagues present data indicating that the number of social connections a person holds does not predict loneliness.[11] Rather, factors such as individualistic cultural values, chronic pain, lack of face-to-face communication (technologisation of relationships), poor quality of relationships and even genetic predisposition towards loneliness are stronger predictors of loneliness.[12–15] The distress associated with loneliness varies depending on genetic sensitivity to this emotional state.[15] High levels of distress intolerance related to isolation can create an unhealthy striving towards connection at any cost that results in inauthentic relationships.[8 16] The craving for a sense of interpersonal connection cannot be fully achieved through inauthentic relationships that are devoid of meaning. Staying in abusive relationships, avoiding vulnerable conversations to maintain favour, joining too many activities so that only superficial relationships can be maintained, and connecting only through the wall of technology are attempts at staving off loneliness or out of the necessity of function, yet miss the mark of attaining true interpersonal connection. In these examples, the other in the I-Thou (I-You) mutually meaningful relationship is replaced with an object in an I-It functional relationship, whereby the object is a person or people being used to avoid loneliness.[8 10 16] In essence, loneliness can tempt individuals to create superficial relationships to soothe distress. While loneliness can negatively impact mental and physical health when experienced chronically, there are benefits to this emotional state. Humanistic-existential theorists might advise to 'sit in the discomfort and breathe through to possibility'.[17] By allowing oneself to experience loneliness and the distress it evokes, a deepened appreciation of isolation and connectedness follows.

The humanistic-existential theory posits that loneliness is a part of the human condition and guides those faced with isolation to live more authentically and with greater awareness.[18] It is likely that the human experience of loneliness increases motivation to attend to social needs, self-preservation and personal interests.[15] In the absence of interpersonal connectedness, there exists an opportunity for self-examination and meaning-making. One might ask: 'How can I improve the quality of my relationships so that I feel connected?' (social needs), 'What source of anxiety might my isolation be pointing to?' (self-preservation) or 'What is the state of my relationship with myself?' (personal interests). Questions that are reflective and encourage deep thinking guide the individual towards creating a meaningful schema in which to understand stressful life events such as prolonged isolation. One research study of Chinese students discovered that meaning-making even serves as a protective factor for suicide by increasing hope.[19] Loneliness can even elicit prosocial behaviour such as sending a child to

sit alone after misbehaving or a member of a group being willing to work through conflict in order to be accepted back into the group. Additionally, isolation provides space for self-reflection and meaning-making. A meaningful life is a positive indicator for mental and physical health as well as social appeal.[20 21] In a meta-analysis of existential therapies, it was found that they have a significantly positive effect on psychopathology and finding positive meaning in life.[22] Furthermore, research has shown that existential therapies can help individuals to find meaning in their challenging life circumstances and reappraise the situation to influence personal growth.[23] Bargdill and colleagues note that when faced with one's fragility, there is an increased consciousness that enables one to pursue a sense of purpose and to appreciate life.[24] This leads to stronger relationships and gratitude. Therefore, the emotional experience of loneliness serves as a reminder to seek meaning in life and to 'surrender ineffective ways of being'.[16] Once the isolated individuals have made sufficient use of this space, they will have gone through a process of examining the disconnect in their life to understand the self-needs present, improved prosocial motivation to connect meaningfully with others and achieved a greater sense of how to live one's life authentically and meaningfully.

Mental health professionals can honour collective existential isolation by challenging systemic factors that negatively impact patient health and well-being. Until these external factors are addressed, many clients in marginalised groups will be unable to achieve sufficient therapeutic outcomes.[7] The power and prestige of the profession can be used to advocate for changes that reduce health disparities between communities. Also, it is imperative that service delivery be adapted for cultural relevance, as there is evidence suggesting less willingness and more stigma attached to seeking out mental healthcare in certain groups.[8] Cooperation with religious organisations[25], non-profits, community groups and the school system can open opportunities for patients to form lasting relationships in a culturally relevant setting. Connection within a caring group of people helps patients to sustain and build on gains made from therapy or pharmacological interventions.

Finally, there is the question of how to address existential loneliness. To this end, patients should be encouraged to become more than just passive consumers of healthcare, but rather explore life's deeper meanings through self-reflection, service to others and community advocacy. By providing opportunities to make an impact on their world and dive deeper into personal meaning, practitioners can affirm patients' dignity and lessen the stigma associated with mental illness.

Events of the past year have exposed an already deepening isolation among people in society. Mental health professionals are often called to provide relief for those most adversely affected by isolation. During this difficult time, the groundwork can be laid for a wider flourishing of mental health service delivery, which addresses systematic fissures in society and allows for the continued growth of the patients we serve. Perhaps, this time has been an opportunity to think outside of the box about our mission and scope. Psychiatry and psychotherapy perform a necessary function that will continue to be used so long as it adapts to a client base in need of guidance for managing pervasive isolation.

REFERENCES

1. González-Sanguino C, Ausín B, Castellanos Miguel Ángel, *et al*. Mental health consequences during the initial stage of the 2020 coronavirus pandemic (COVID-19) in Spain. *Brain Behav Immun* 2020;87:172–6.
2. Ramos M. Danita, "Self-Concealment, Perceived Discrimination, and African American Treatment Choices for Major Depression" (2019). Walden Dissertations and Doctoral Studies. 7492. Available: https://scholarworks.waldenu.edu/dissertations/7492
3. MHA. Mental health America. Available: https://www.mhanational.org/
4. Burns DD. *Feeling good: the new mood therapy*. New York: Collins, 1999.
5. Stephenson-Hunter C, Dardeck KL. Locus of control and health promotion for marginalized populations. *J Health Soc Behav* 2019;13:115–27.
6. Ahmed N, Conway CA. Medical and mental health comorbidities among minority racial/ethnic groups in the United States. *J Health Soc Behav* 2020;14:153–68.
7. Fromm, E. *The art of loving*. New York, NY: Harper & Row, 1956.
8. Yalom ID. *Existential psychotherapy*. New York, NY: Basic Books, 1980.
9. Hart J. Toward an integrative theory of psychological defense. *Perspect Psychol Sci* 2014;9:19–39.
10. Buber M. *Between man and man*. New York: Macmillan, 1965.
11. Matthews T, Danese A, Wertz J, *et al*. Social isolation, loneliness and depression in young adulthood: a behavioural genetic analysis. *Soc Psychiatry Psychiatr Epidemiol* 2016;51:339–48.
12. Lee Y, Ko Y. Feeling Lonely when not socially isolated: social isolation moderates the association between loneliness and daily social interaction. *J Soc Pers Relatsh* 2018;35:1340–55.
13. Emerson K, Boggero I, Ostir G, *et al*. Pain as a risk factor for loneliness among older adults. *J Aging Health* 2018;30:1450–61.
14. Jin B, Park N. Mobile voice communication and loneliness: cell phone use and the social skills deficit hypothesis. *New Media & Society* 2013;15:1094–111.
15. Spithoven AWM, Cacioppo S, Goossens L, *et al*. Genetic contributions to loneliness and their relevance to the evolutionary theory of loneliness. *Perspect Psychol Sci* 2019;14:376–96.
16. Bland AM. Existential Givens in the COVID-19 crisis. *J Humanist Psychol* 2020;60:710–24.
17. Jackson T. *Keynote address*. Chicago, IL: Fourth Annual Conference Society for Humanistic Psychology, 2015.
18. Moustakas CE. *Loneliness*. Englewood Cliffs, NJ: Prentice Hall, 1961.

19 Lew B, Chistopolskaya K, Osman A, *et al*. Meaning in life as a protective factor against suicidal tendencies in Chinese university students. *BMC Psychiatry* 2020;20:73.

20 Hooker SA, Masters KS, Park CL. A meaningful life is a healthy life: a conceptual model linking meaning and meaning salience to health. *Rev Gen Psychol* 2018;22:11–24.

21 Stillman TF, Lambert NM, Fincham FD. Meaning as magnetic force: evidence that meaning in life promotes interpersonal appeal. *Soc Psychol Personal Sci* 2011;2:13–20.

22 Vos J, Craig M, Cooper M. Existential therapies: a meta-analysis of their effects on psychological outcomes. *J Consult Clin Psychol* 2015;83:115–28.

23 Abel L, Walker C, Samios C, *et al*. Vicarious posttraumatic growth: predictors of growth and relationships with adjustment. *Traumatology* 2014;20:9–18.

24 Bargdill RW, Marasco-Kuhn JL, Muron AP, *et al*. One way that meaning is created: a phenomenology of meaningful events for young adults. *J Humanist Psychol* 2019;1:002216781882466.

25 Heseltine-Carp W, Hoskins M. Clergy as a frontline mental health service: a UK survey of medical practitioners and clergy. *Gen Psychiatr* 2020;33:e100229.

Dr Vanessa Brown graduated from the Michigan School of Psychology in USA in 2013 and received a doctorate degree in Clinical Psychology with a specialty in Humanistic-Existential Psychology. She is on the executive board for the Society for Humanistic Psychology, Division 32, of the American Psychological Association and serves as their Continuing Education Chair. She is also on the board for the Journal of Humanistic Psychology and is a practicing Licensed Psychologist. Her main research interests include integrating humanistic and feminist theory in the therapy room, spiritually-integrated care and social justice.