Age and Social Isolation Submission

Category: Best practice and ideas that could be shared across Scotland, including examples of targeted support or initiatives.

“Loneliness is the awareness of complete isolation; and are not all our activities self-enclosing? Though our thoughts and emotions are expansive, are they not exclusive and dividing? Are we not seeking dominance in our relationships, in our rights and possessions, thereby creating resistance? Do we not regard work as ‘yours’ and ‘mine’? Is not our whole tendency to isolate ourselves, to divide and separate? The very activity of the self, at whatever level, is the way of isolation; and loneliness is the consciousness of the self without activity. Activity, whether physical or psychological, becomes a means of self-expansion; and when there is no activity of any kind, there is an awareness of the emptiness of the self. It is this emptiness that we seek to fill, and in filling it we spend our whole life.”

I am a General Practitioner in Scotland and am also conducting research with Aberdeen University on mindfulness for people with chronic pain. I am from Sri Lankan Muslim background and have spent the last five years living alone in a small village on the west coast of Scotland. I would like to write about: 1) my experience supporting individuals who are experiencing loneliness through my work as a GP; 2) my learning on this area from my own research; and 3) my personal experience of loneliness. This working, learning and experiencing has led me to ideas for initiatives that may be beneficial to society on the area of ‘loneliness’.

1. General Practice

Working in General Practice, I see people (both young and old) suffering from loneliness. My consultations as a GP primarily involve listening. At the back of my mind is my own agenda: the possible diagnosis, the tasks I should get done for QOF, the amount of time I have to see this person, and remaining thoughts from the last patient I saw. I can play the expected role of the GP: to take a history, to examine, to make a diagnosis and to prescribe a treatment, without ever really truly listening. The individual comes and goes and we both remain isolated, untouched by our encounter. When I am able to put my agenda aside and really meet the person sitting in front of me, human to human, with shared suffering and shared longings, then for those moments we journey together. I am no longer the ‘Indian-
looking female doctor’ and the patient is no longer the ‘elderly disabled lady with bowel problems’. For those moments there is just connection, companionship and simple ‘being with each other’. Both myself and the patient are enriched by the encounter.

If I am truly present with myself, then I am available to really listen, to really meet another. If I am not present, if my mind is occupied with thoughts (thoughts about what I should be doing, or wish I was doing, judgements about the person in front of me, or about myself), then I am not available to truly meet another. This quality of ‘presence’ is also known as mindfulness.

2. Research with patients with chronic pain

My research work has involved a mixed methods study looking at the experience of 23 patients with chronic pain in a mindfulness programme. 83% of participants were ‘older’ (aged 50 to 81).

Participants described to me how alone they often felt due to their pain. One older participant described feeling ‘desperately alone’, with a sense that others did not understand what he was going through.

There was often a resistance to their pain, wanting their experience to be different. One older participant described how not accepting that part of her experience led to her ‘automatically shutting off from other things’ and, in that way, shutting off from life.

The mindfulness meditation practices learned involve being present with experience, accepting it in its totality. This can begin with bringing awareness to the breath or to sensations in the body. One older participant described how this made her ‘engage more with everything’ and led to her ‘taking time to really appreciate things’.

3. My own personal experience

“People can feel lonely when not isolated, and isolated when not lonely. Some people might be happy to be isolated and choose to be so. Social isolation tends to have negative consequences when it makes a person feel lonely.” (From Inquiry remit)

I have been exploring the area of loneliness as it is something that I have experienced, at times, in my life. For me, the greatest loneliness occurs, not when another person is not with me, but primarily when I am not present with myself. When I am longing for things to be different, when my mind is far away from where I am now, then I am deeply lonely. Some days I would be sad when the sun shone. I was sad because the shining sun was wasted as I was not present to appreciate it. Whilst social isolation is an important factor involved in loneliness, reflecting the needs of the individual for community and companionship, I think the issue of
loneliness is much broader and primarily begins with the self. If I am rejecting myself and aspects of my experience then I am very lonely. On the other hand, if I am present with myself, with what is happening in my experience, then I may be alone but I am not experiencing loneliness. This experience has reaffirmed my own practice of mindfulness.

Recommendations

Based on the three areas described, I would recommend initiatives introducing mindfulness to both the young and the older members of society as a way of addressing the issue of loneliness. There is limited availability of mindfulness courses within the NHS\(^3\) and within schools. Mindfulness courses could be introduced at a community level, with availability for the general public rather than being limited to patients with specific conditions. Availability of mindfulness courses for GPs and NHS staff could be of benefit to GPs, staff and the public.

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References