

Mental wellbeing in a pandemic: the role of solidarity and care

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COVID-19 deeply affects many spheres of life. Lockdown measures implemented worldwide have accentuated mental wellbeing changes in the population from the perspectives of space and social relations. These changes leave lasting imprints on individuals and communities. This article draws upon solidarity and care ethics in exploring their role in rebuilding mental wellbeing in the light of constraints arising from lockdown. The diversity of responses to physical and social isolation during the pandemic illuminates the distinctly relational nature of human beings, offering the opportunity for care and solidarity to respond to mental wellbeing challenges in an inclusive and context-sensitive way.

Introduction

COVID-19 deeply affects many spheres of life, with the repercussions being felt acutely by the vulnerable segments of the population. Nationwide lockdown measures adopted by many countries to halt the spread of infections and save lives have curtailed the movements of people and non-essential goods (Iacobucci, 2020). Mandatory isolation led to concerns surrounding the effect on the population mental wellbeing, the ‘trauma’ associated with lockdown and broader questions regarding health deceleration of such containment measures. Public health history is replete with documented effects of how pandemics affected population mental wellbeing: the 2014 Ebola outbreak and SARS pandemic recorded long-term population anxiety, post-traumatic stress disorders and other psychological harms arising from experiencing life-threatening situations and social isolation (Maunder *et al.*, 2008; Koh and Sng, 2010; Shultz *et al.*, 2015). COVID-19 has witnessed significant decline in mental wellbeing compared to pre-pandemic across countries that are already struggling with mental health issues (Perkins, 2020; Chatterjee, 2020; Ettman *et al.*, 2020; Czeisler *et al.*, 2020; McGinty *et al.*, 2020; Public Health England, 2020). These published findings highlighted the correlations between elevated mental distress and increased time spent at home. The pandemic has, at the time of writing, yet to see an end, with the imminence of continuous waves of infections, risking further lockdown, and threatening stress cushions supporting individual resilience in crisis. It is unsurprising

that a mental wellbeing pandemic has already happened which may well become long-term psychiatric illness.

The close associations between mental wellbeing and implications from lockdown merit further consideration. Mental wellbeing as an important public health matter is exacerbated by lockdown in a pandemic. Various external and internal factors shaped mental wellbeing, ranging from social and familial relationships (or the lack of); employment options, living arrangements, childhood trauma and socio-economic determinants (stress and (dis)advantages). While a range of elements affects mental wellbeing, the immediate effect of a lockdown is felt acutely from the physical and psychosocial elements, particularly within the contexts of space and social relations. Space and social relations directly interact with the inhabitants, creating continuous, influential constraints experienced by the individual on a daily basis. These two elements are thus strikingly intertwined with mental wellbeing. Lockdown has reconfigured our relationship with the spaces that we inhabit, and our relationships with self and others. As mental wellbeing is a public health concern, rebuilding population mental wellbeing require solidaristic actions. Exploring these two significant dimensions enables us to examine the influences that shape the contours of mental wellbeing during a pandemic and beyond, and how care ethics and solidarity can offer sound ethical remedies to the socio-spatial challenges posed by lockdown to mental wellbeing.

I have sketched an overview of the current state of mental wellbeing arising from the pandemic. This will be followed by an exploration of the significance and

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implications of lockdown on mental wellbeing from the spatial and social relations perspectives. One of the key stressors that disrupt the mental wellbeing equilibrium in lockdown is social isolation, pushing the boundaries of mental resilience into crisis. Mental wellbeing risks being underemphasised in the face of global health pandemic, as the priority is often shifted towards treating infectious patients and developing vaccines. However, inattention to the adverse effects of lockdown on mental wellbeing precipitated by the pandemic would risk long-term health consequences. Building on the discussion outlined on these points, solidarity and care ethics are then considered to identify how they can apply in a mental wellbeing context. The article concludes with options towards rebuilding mental wellbeing using caring, solidaristic actions at distinct levels of the population.

Mental Wellbeing and Lockdown: Significance and Implications

Wellbeing is characterised as ‘positive human functioning, extending beyond a physiological or biomedical notion of health to encompass the emotional, social and spiritual dimensions of what it means to be human’ (Conradson, 2012:15–16). It highlighted positive traits that correspond with human flourishing rather than simply surviving. Historical conceptualisations of wellbeing, originally drawn from classical Greece studies denote *eudaimonic* elements of wellbeing as happiness and prosperity, later assuming a more hedonic, Millian interpretation of the maximum happiness for the greatest number of people (Fuller, 2012). Modern conceptions of wellbeing, in addition to the *eudaimonic* and hedonic approaches, include psychological, social, spatial, environmental and economical considerations which provide a contextual background to the meaning of wellbeing (Fuller, 2012:4, 6–7). Individuals and local communities similarly influence notions of wellbeing; the latter exemplified by *Maori* indigenous interpretation of wellbeing as closely and relationally connected to and resonated with the environment, social and ecological influences (Fuller, 2012:5; Conradson, 2012:16, 22–23). The links between places and social relationships as important determinants to wellbeing signalled the relational aspects of mental wellbeing. This can be contrasted with a more individualistic ideal of happiness in affluent, western societies (Carlisle *et al.*, 2009; Davidson *et al.*, 2015).

Mental wellbeing is a broad concept that encompasses mental health and the spectrums of mental states occurring within and beyond this range. Mental health is often associated with an optimum functioning within

individuals and with their external environment, denoting an absence of illness and the importance of social, psychological and environmental influences in maintaining the balance (Sartorius, 2002; Bhugra *et al.*, 2013). While the construction of mental health remains wedded to bio-psychiatry domains and reduced to representations of illnesses, contemporary understanding of mental health demonstrated the move towards a more integrated approach, encompassing ecology, epidemiology, arts, humanities, trans-cultural health and social psychology (Manwell *et al.*, 2015). Mental health, at its fundamental level, involves an individualised construction of capacity for exercising choice in connecting with society (Manwell *et al.*, 2015). This posits a modern bioethical understanding of agency, and autonomy in forming or disengaging from the society or the outside world; an essential component in determining the wellbeing of the person in relation to achieving personal goals in life. For the purpose of the discussion, the term mental wellbeing is preferred over mental health, as the former is more inclusive to adequately accommodate the multitude of potential factors that affect its equilibrium, and influencing how mental wellbeing is shaped and understood according to the context in which it assumed.

Lockdown, precipitated by the pandemic is a constraint, both physical and psychological. Its significance lies in part as constituting a stress-inducing event which activates specific biological or behavioural responses in the brain (Anisman, 2015). The uncertainties arise from the length of lockdown, the departure from familiar or routine activities, and the ambiguities surrounding the present and the future of work, social arrangements and state of mind. Stressors elicit different stress levels and responses according to the individual’s personal attributes and socio-cultural contexts (Anisman, 2015:8, 11, 20), with lingering negative and positive consequences on individuals and across generations. Lockdown necessitates the normalisation or renormalisation of everyday life through re-establishing physical, social and economic activities. On a macro level, it warrants negotiating household living arrangements, either for protection from violence or peaceful coexistence, and restricting movements to congregate in some communities. Prolonged isolation, on a micro level, generates feelings of alienation and invisibility, compels sudden behavioural changes which gives rise to claustrophobic sensations, precipitates existing depression, and in some instances, demands the willpower to control social media influx, which cumulatively threatens mental wellbeing. These psychological influences stimulate immediate behavioural responses with lasting effect,

resulting in restlessness, lethargy, or disrupted sleeping patterns in response to coping with ambiguities. These reactions represent the diverse mosaics of mental wellbeing during the pandemic, where everyone is bound by a universally shared sentiment of uncertainties.

There are emerging narratives of how mental wellbeing is affected by lockdown with long-term consequences on public health. Early reports indicated that the residents in Wuhan at the height of the pandemic suffered from mental distress dealing with the death of loved ones, facing the uncertainties surrounding infection diagnoses, and being in restrictive spaces, which cumulatively pushed the boundaries of emotional balance (Kanthor, 2020; Weerasekara and Roxburgh, 2020). Across the globe, people experienced a trajectory of mental wellbeing changes and repeated, heightened anxiety in limited spaces, constantly reacting to external events, triggering feelings of loneliness, boredom, frustrations, anger or helplessness with oneself or with others, such as couples who are separated, bereaved or in the process of divorce but living under the same roof (Horton, 2020; Mills, 2020; Payne, 2020). The gravity of the situation can be more profound in abusive households, or the elderly, disabled and vulnerable groups. The trauma that people experienced consequent to lockdown risks unnoticed and may resurface years later. Such harm may appear in people with existing mental illness, or in individuals who are seemingly well, but have repressed those feelings because of their personality or roles, such as carers or those who assumed a larger share of caring responsibilities in organisations or households. It is clear that spaces, together with the range of activities and experiences derived from associations with space affect mental wellbeing, thus advancing the concept of *space* beyond its depiction as stationary background where social interactions take place (Fuller, 2012:3). Confinement arising from mandatory lockdown thus exacerbates mental health issues and poses a material impact on the mental wellbeing of healthy individuals.

Space: Sanctuary or Entrapment?

Space, at a fundamental level, provides security and sanctuary (Wight, 2012). It also connotes visibility, evidenced from the external and internal structures, and represents human history and development (Wight, 2012:237). Space is relational to human beings. The emotional aspect of being attached to specific places (Conradson, 2012) and the relationship between place-making and physical and mental wellbeing (Wight, 2012) are relevant in demonstrating how space interacts with mental wellbeing. Wight (2012) conceived

wellbeing as ‘a product of place-making, engaging body, mind and spirit’ while place is conceptualised as ‘the integration of physicality, functionality, community and spirituality’ (232). Space and place are thus considered to be fluid concepts, occupying both physical and psycho-social spheres (Logan, 2019).

Space has particular significance to lockdown. It signifies a spatial transformation in the individual’s life, interacting with the person occupying it and how the person perceives its role, limits, relationship and co-existence within that space, the engagement with and disengagement from the surroundings and with self. Reference can be made to Eckenwiler’s (2018:562) conceptualisation of ‘people as ecological subjects, creatures situated in specific social relations, locations and material environments’ which aptly corresponds to the relational aspects of human beings within the context of place-making. For example, people living in limited spaces with no access to gardens or outdoor areas perceived space differently from those inhabiting comparatively more spaces, consequently creating distinct dynamics with the space they inhabit (Hanley, 2020). The difference becomes stark once we consider the availability of working from home, where those employed in the knowledge economy have more options to negotiate work-living space compared to those who are on the lower socio-economic scale.

A substantive body of research has continued to emerge in the past decade identifying the associations between architecture, green spaces and positive wellbeing (van den Berg *et al.*, 2010; Connellan *et al.*, 2013; Nutsford *et al.*, 2013; Cohen-Cline *et al.*, 2015; Wood *et al.*, 2017; Eckenwiler, 2018). These research suggest architectural or environmental factors housing individuals that contribute towards positive wellbeing, such as aesthetics, interior design, lights, noise, smell, windows, privacy and creating meaningfulness. A recent approach examines the vitality of space, using the example of asylum seclusions to demonstrate the distinctions between private spaces as enablers of exercising choice and control over personal activities and encroachment as stressor points (Brown and Reavey, 2019:136). In drawing parallels to asylums, the authors highlighted the multilayered significance of seclusion, revealing the paradox between protection, convalescence and confinement and harm (Brown and Reavey, 2019:134).

Spaces trigger people’s response in different ways. When lockdown became imminent, it generated the immediate reaction of losing control, first in relation to outside activities, and then, in relation to their (lack of) space. These rapid chains of reactions can result from either compact accommodations (physical) or

abusive or repressed environments (psychological). They produced the experience of being deprived of physical connections, and of being *trapped* or *contained* within the (invisible) walls of their homes. While lockdown is not house arrest, the attribute of movement restraint resembles restrictions for a length of time. Home has thus become a device that subject people to its “power”. Where home can mean an escape from external pressures, a place of comfort and relaxation, a source of creativity, it can also represent a space that terrifies, punishes, and a source of distress and survival. The asylum seclusion example sheds light on the clear space designations for specific purposes, which influenced the inhabitants’ experiences, particularly concerning notions of “agency, power and entrapment” (McGrath and Reavey, 2018:2, 11).

Contemporary household patterns which have become increasingly blended revealed disparities in spatial encounters for those with less security and stability (McGrath and Reavey, 2018:12). The despair of living in confined spaces may, in some instances rekindles subdued addictions, such as compulsive gambling, internet or alcohol addiction or drug abuse. In living within negative spatial settings, the internal and external stressors produced by the lockdown would elicit distinct suffering or revive previous trauma. This could be particularly severe for people facing lockdown for months alone or for those who seek to escape the pressures of crowded households. Confined spaces amplified the overlooked dimensions of gendered labour and caregiving responsibilities as significant factors affecting mental wellbeing in a pandemic. While health conditions and socio-economic status influence mental wellbeing, prevailing caregiving realities shaped by gender, which disproportionately affected women (Wenham *et al.*, 2020; Burki, 2020) and people living with children and the elderly in urban areas with low household incomes significantly altered their mental wellbeing. The range of lived experiences within the pandemic contributes to varied levels of pressures experienced by the inhabitants, resulting in disparate distribution of mental and emotional hardship. Such asymmetry of mental wellbeing burdens produced consequential implications for individuals, necessitating distinct considerations towards mitigating actions.

Mental Wellbeing and Social Relations

Mental wellbeing is socially embedded. It is entwined with social relationships, and interlinked with a range of factors including social class, race, gender, religion, educational level, surrounding neighbourhood

characteristics, personality, or self-esteem. Social support is widely considered as essential to physical and mental wellbeing (Horwitz, 2007; Cacioppo *et al.*, 2011; Paine and Pudrovskaya, 2019; Rugel *et al.*, 2019), as family and kinship provide sources of ‘social structure in communities’ (Semu 2019:105). These support networks benefit people through their presence and content, fulfilling the human need for care and appreciation (Turner *et al.*, 2014) and for survival and prosperity. Lockdown challenged the maintenance of social relations and relationships, particularly in terms of their availability and sustainability. Living arrangements, while often understood in terms of space, also formed a material part of the social world. They reveal the changes in familial dynamics when confined within the space and the shifts in the roles and functions of each member, disclosing the suffering or healing of the individual self in response to emotional or psychological distress. Further, as ideas of family and kinship evolve over time to include same-sex couples, friends, multi-generational households, or blended families, they generate slightly more complex interactions. Consequently, positive arrangements promote wellbeing, and vice versa. Emotional currents running through these interactions under ordinary circumstances can bind or break the self and the social units, inevitably affecting the individual and the group. Being confined in limited spaces compels people to experience amplified emotional upheavals while learning to navigate existing social relations. Additionally, the emotional burden experienced by caregivers as a result of converging obligations and interests arising from home-schooling, housework and maintaining employment commitments further undermined opportunities for nurturing critical, supportive social relationships during the pandemic. These developments have detrimentally affected mental wellbeing.

Modernity, economic independence and educational choices have increasingly enabled single household options. Such individuals may either desire increased frequency in online social contact or embrace the opportunity to be in solitude. The length of time in lockdown, however, can considerably affect the mental wellbeing of single household occupants. The initial phase of lockdown may produce either anxiety or relief, and fluctuates over time, precipitated by constant adjustments in daily life and activities in response to isolation. Responses can range from regression into inactivity to rediscovering activities that will act as substitutes to their ‘normal’ pre-lockdown life. As individuals accepted the reality of lockdown, they adapt their mental perceptions and behaviours in response to the new environment. The

paradigm shifts in mental wellbeing occurring in individuals are similarly affected by the personality and the type of social network they have. For example, individuals who considered themselves extroverts may require more social contact and online activities to maintain their mental wellbeing compared to those who are more introverted. These developments captured the reshaping of relationships, happening within the self, and with space, in both physical and psychological terms.

Lockdown has largely sundered physical and social interactions and deepened problems in compact households, resulting in the worsening of mental wellbeing. The latter strengthened the significance of place as influencing the inhabitants, where relationships and meanings are continuously forged and recreated (Eckenwiler, 2018), corresponding to the mental wellbeing trajectories as affected by social and spatial constraints during lockdown. The continuous interactions with the self and with the space and other inhabitants, combined with a perceived loss of agency produced diverse outcomes for different individuals. While there is some degree of control in favourable environments creating a neutral or positive response, those who continued to experience the loss of agency or the lack of opportunity to reach out will experience potentially long-lasting adverse effect on their mental wellbeing. The enduring mental wellbeing effects are thus reflected more clearly through the physical and psychosocial-spatial prisms.

Responding to Mental Wellbeing Challenges in Lockdown: Solidarity and Care

The interactions between space, social relations and mental wellbeing in a pandemic reflect important challenges to public health and require sustained effort to respond to continuous mental wellbeing challenges. The following discussion examines the role of care ethics and solidarity in alleviating mental distress arising from lockdown, shifting the focus from feeling ‘contained’ to being cared for on individual and population levels. The role of solidarity and care ethics may not be immediately apparent. However, an appreciation of the premise that mental wellbeing is a public health matter can refocus our attention towards the important contribution of solidarity and care ethics in navigating mental wellbeing challenges.

The Role of Care and Solidarity

Care ethics. Care ethics has a notable feminist beginning but has gained more mainstream attention within bioethics. Care ethics recognises the importance of human interactions in relation to oneself and others (Gilligan, 1982, 1993), accentuating the inter-connectedness for human flourishing, and acknowledging human beings as moral subjects (Jennings, 2018). An ethic of care is primarily framed within caregiving settings (Noddings, 1984; Kuhse, 1997), indicating notions of mutuality and connectedness as features of daily life (Pettersen, 2011), and underpinned by lived experiences and emotion (Held, 2006). Recent interpretations of care ethics include notions of respect, responsibility, meeting needs and relationality (Herring 2013:14). Tronto’s (1993:137) formulation of care consisting of both disposition and practice is relevant in considering how to care in a pandemic climate. They include attentive, responsible, competent and responsive actions in appraising the situation and surrounding social circumstances carefully: what we have, what we are lacking in, what we can do (within our ability) and make judgments that are contextual in nature. The relational interpretation of care underscores the relationality among people, which in turn enabled a locally-owned understanding and practice that involves both thought and actions.

Care is often considered as moving from one person to the other, but rarely to oneself. There are other ways of rendering the relationship represented as such. Relationships should be envisaged to include not only relationships with others, but also relationships with our *self* and our interactions with the environment, space and place. This interpretation is broad enough to accommodate actions for self-care, and care for others in times of isolation. It is also adequate in capturing the inherent vulnerability of being human, and the mutual dependency in social relationships as part of the fabric of daily life. Lockdown continuously tests and exposes these seams of vulnerability. We have seen how mental wellbeing is affected by the emotional, social and spatial evolutions of lockdown, whether separated or in limited spaces confined with others. Caring actions involve identifying and recognising the physical and psychological effects of restrictions on our movements—resulting in either a temporary or permanent loss of sense of belonging or dissociation with the wider world. On an individual level, accepting the reality of the situation can help ease the shock of lockdown as it allays one of the stressors to our mental wellbeing and realigns our behavioural response to what we can do within the confines of the new situation. Assessing our personal

circumstances enables us to seek help upon identifying the insufficiency. However, our actions for self-care towards regaining our agency can be limited by available resources. While some actions can be available immediately, such as accessing external spaces, the underlying problems persisting in crowded or solitary households, gendered labour and unequal distribution of caring responsibilities and their effect on mental wellbeing require external interventional support. This is where solidarity performs the important function of cementing caring actions on a household, community or population level.

Solidarity. Solidarity as a concept has attracted engaging conversations in contemporary debates within the field of public health ethics and bioethics (Baylis *et al.*, 2008; Prainsack and Buyx, 2011; Dawson and Verweij, 2012; Jennings, 2018). Solidarity with its Latin roots, *solidus* was applied in Roman law as *obligatio in solido* signifying obligations requiring fulfilment or performance of specific actions (Reichlin, 2011:366). The concept is also influenced by the French political revolutions which represented *standing together* for a common cause and Christian notions of *fraternity*, and mutual assistance on the basis of equality and human dignity (Prainsack and Buyx, 2011:6, 7). A modern interpretation of solidarity consists of ‘shared practices reflecting a collective commitment to carry “costs” (financial, social, emotional or otherwise) to assist others’ connoting actions, similar to care ethics as a practice (Prainsack and Buyx, 2011: 46, 47). This interpretation was further outlined as three tiers of solidarity: interpersonal level, group practices and contractual and legal manifestations, thus transcending the individual boundaries. Heyd (2015) alerts us to another dimension of solidarity, by regarding solidarity as fundamentally local instead of universal, partial and reflective ‘(an emotion mediated by belief and ideology, interest and common cause)’ (55). These elements are useful in considering measures for mental wellbeing challenges from an individual level to a national/population context. While Heyd highlighted the localised nature of solidarity, it does not necessarily preclude its universal trait. Solidarity can be both universal and local. As indicated above, while lockdown is a universally shared sentiment, it is similarly experienced individually. These shared experiences are then influenced by external factors, such as resources, socio-economic conditions and inter-intrapersonal relationships. It is unsurprising that solidarity has become synonymous with “complex, multilayered concept” (Prainsack and Buyx, 2011:36).

Solidarity, at its very fundamental level, signifies mutuality or unity in sentiments, emotions, feelings, or in actions and activities. Common elements of solidarity include standing together (e.g.: in the face of collective threat), mutual support, cooperation and shared values (Hayry, 2005; Reichlin, 2011; Dawson and Verweij, 2012). It connotes the mutual interdependence between individuals, including the vulnerable populations in promoting the stable functioning of society, which in turn advances conditions for social life (Baylis *et al.*, 2008; Reichlin, 2011; Kenny *et al.*, 2010; ter Meulen, 2015), thus implying mutual responsibility to the wellbeing of fellow humans and societies. Such interpretations not only connote the relational nature of solidarity but also bridge the links between solidarity and care. Recognising our mutual vulnerabilities, individuals and institutions become essential stakeholders in transforming healthcare provision (Chadwick, 2015). The interdependence element speaks to the imperative of not only recognising the particular needs and interests of vulnerable people but also the collective responsibility in taking actions to defend and promote their interests as shared responsibility for the flourishing of humankind. This appreciation accordingly identifies with the notion of shared vulnerabilities and common humanity, thus shattering the boundaries between ‘us’ and ‘them’.

Although solidarity is referenced in primarily four contexts: public health, justice and equity of healthcare systems, global health and a European value (Prainsack and Buyx, 2011:22), the concept has featured in arguments for obligations in healthcare provision (Davies and Savulescu, 2019), social solidarity in healthcare based on human dignity (Reichlin, 2011), considerations of just distribution of resources, with special attention to the vulnerable population (Holm *et al.*, 1999), structural injustice in the USA (Gould, 2018) and relational solidarity and justice in health care (ter Meulen, 2015). In the context of pandemic planning within public health, Baylis *et al.* (2008) have argued for specific awareness to marginalised, socio-economically vulnerable subpopulations, underpinned by relational personhood and relational solidarity. As demonstrated above, the pandemic has magnified important but neglected problems with social inequality, exemplified by the divide that emerged in spatial and social settings and how these factors contribute to mental distress.

The care ethics–solidarity relationship. The relationship between care ethics and solidarity becomes visible when we appreciate their shared attribute of relationality. Relationality is the underpinning characteristic in the care-solidarity discourse, which refers to the implicit

interconnectedness of human vulnerability and mutuality of circumstances. Our wellbeing is bounded with one another (Baylis *et al.*, 2008; Jennings, 2018, 2019). Such a reflection could not be truer in a pandemic. Care is embedded in solidarity, and solidarity is deficient without care. Solidarity is thus a necessary feature of care. Although care is more readily identified as relational and solidarity is often associated with social justice, responsibility and rights, relationality is a striking feature in both concepts and is not emphasised adequately in the latter. Solidarity enables caring practices because it recognises the relational nature of individual beings and communities. Further, solidarity, as identified above, represents the coming together, and shouldering of burdens; thus entailing a relational understanding to it to fully comprehend the relationship and responsibilities between different actors in taking actions for maintaining mental wellbeing. An account of solidarity and care without relational consideration is hence misconceived and lacks the necessary ethical imperative in appreciating its role.

Another helpful construct of relationality in anchoring solidarity and care is Jennings' (2018) explication of solidarity as comprising of *standing up for*, *standing up with* and *standing up as*. In particular, the conceptualisation of 'attentiveness' in three aspects: 'attentive rehabilitation of the other' (helping to establish a new way of dealing with the situation); 'attentive companionship with and for the other' (that people are assured that they are not abandoned) and 'attentive commitment'; a stronger duty which leads to health policy changes, translating to a commitment to a system to create an 'ecology of care' (560) provides a concrete direction towards actioning caring, solidaristic actions towards rebuilding mental wellbeing. Although this conceptualisation has some similarities with Prainsack and Buyx' (2011) three tiers of solidarity, Jennings' formulation has a particular relevance to mental wellbeing that captures the range of possible actions underpinned by care ethics without the need to resort to notions of similarity.

The contributions of solidarity and care ethics to population mental wellbeing: options and prescriptions for addressing mental wellbeing challenges in a pandemic. Mental wellbeing is substantially weakened by lockdown constraints from the social and spatial perspectives. Solidarity and care offer a framework to ground practical actions in addressing mental wellbeing decline arising from the constraints posed by the pandemic. Mental wellbeing is a personal and shared experience and can be envisaged as a common vulnerability across communities in a pandemic.

Verweij (2020) has emphasised the importance of solidarity during the pandemic, on the basis that the pandemic affects the entire population, thus requiring joint resolution as a community to confront the risks together. As solidarity is both local and universal, it can apply to mental wellbeing challenges at the individual, household and population levels. The options and prescriptions offered below illustrate some of the ways in which solidarity and care can address the challenges with deteriorating mental wellbeing or minimising its damage during and after the pandemic at distinct levels.

Providing clear, timely information to the public as lockdown unfolds is a population level measure that acknowledges the mutuality of lockdown implications. As demonstrated above, the availability of space and social relations can either inhibit or promote mental wellbeing. This is particularly pertinent in overcrowded households in primarily economically deprived communities where they are most likely to experience heightened mental distress from prolonged physical proximity and the inability to create or access additional spaces while negotiating their daily activities. Clear communication of information enables people to realign their responses in dealing with the uncertainties generated by lockdown and most importantly encourage the affected communities to access essential mental wellbeing services. Equipping the community with relevant information in preparing for sudden changes can transform these moments of weaknesses to one of strength, consequently engendering solidarity in confronting the restrictions in living arrangements and social relations arising from the pandemic. As Czeisler and colleagues (2020) rightly observed:

Community-level intervention and prevention efforts should include strengthening economic supports to reduce financial strain, addressing stress from experienced racial discrimination, promoting social connectedness, and supporting persons at risk for suicide. . . Communication strategies should focus on promotion of health services and culturally and linguistically tailored prevention messaging regarding practices to improve emotional well-being. (1055)

Solidarity in caring for a fragmented mental wellbeing on a population level means recognising and appreciating the microscopic factors and their interactions with existing conditions and how lockdown has implicated the population. For example, actively gathering information regarding risks posed to mental wellbeing in the community during the pandemic arising from lockdown restrictions manifests a collective endeavour in identifying areas of vulnerabilities and planning

responsive policy interventions. The active gathering of crucial information is beneficial in mapping risk profiles based on the communities' demography and identifying distinct stressors within the community to accurately understand the degree of harm exposure or risk factors in addressing the implications of lockdown to their mental wellbeing. Grasping an accurate profile of community mental wellbeing arising from the lockdown can foster a local and indigenous understanding of mental wellbeing, paving the way to formulate appropriate response strategies. For example, identifying at-risk populations are effective measures to 'inform policies to address health inequity. . . and increasing access to resources for clinical diagnoses and treatment options', including the expanded use of tele-health (Czeisler *et al.*, 2020:1054). This approach situates caring, solidaristic interventions that correlate with the lived experience, limitations and realities of the communities. It permits inclusive, sensitive steps that not only acknowledge the systemic inequalities that contribute to mental wellbeing decline but also enables policymakers to reframe action plans that sought to eradicate policies that curtail access to mental wellbeing services and introduce interventions that promote and safeguard population mental wellbeing beyond the pandemic.

Mental wellbeing vulnerability profiling is but a preliminary step towards establishing responsive strategies for the population and the affected individuals. A solidaristic care-based policy can guide important discoveries of the fraying safety nets surrounding neglected groups; the unbefriended, the homeless, the disabled, those living in fear of domestic violence, the most vulnerable or those who are estranged from families. They are the most vulnerable during lockdown, with severe effect on their mental wellbeing, being gravely limited in financial support. Additionally, the insights gleaned from these discoveries can direct us to the neglected effects of lockdown on working families and gendered labour identified above. Assumptions surrounding ideal images of secure households with sufficient resources are unhelpful in discerning the mental wellbeing effects of the oft-marginalised individuals and the specific support that can be offered to them. For example, stay-at-home orders are rendered futile for the homeless, because the space that they inhabit is now no longer available, while victims of domestic violence suffer increased physical and psychological harm in lockdown. What and how can solidarity and care offer to address these distinct, yet important concerns?

People who are homeless, estranged from families, and the unbefriended may find that space and social relations are essential for their survival during lockdown.

It is the reality that preserving mental wellbeing is only practicable where basic needs are fulfilled. Solidaristic interventions here include recognising and rectifying structures that hindered accessibility to vital services, which extends to broader issues such as employment and security of income and accommodation. It is essential, at the very basic level, to ensure that they do not slip off the radar and become invisible. Solidarity, in recognising the inherent relationality among people, means standing up for them and standing up with them. Multilevel support system should be established to offer various levels of support that meet the needs of the individuals, from a basic level to more specialised services. Basic level support includes food and safe space, alternative housing arrangements, while specialised support involves therapy, and legal or psycho-social support, such as online therapy or counselling sessions (provided that internet access is widely available). Indeed, the awareness of a shared vulnerability and hardships arising from the pandemic had prompted actions to establish remote support services to cope with surging mental wellbeing crisis (anxiety, depression, poor mental health) during lockdown and the pandemic (Taylor *et al.*, 2020; Public Health England, 2020). Where people do not have access to support, or being in solitary confinement, social support workers, mental wellbeing counsellors or therapists play a pivotal role in intervening before their mental wellbeing deteriorated. Information about available support needs to be disseminated so that people are aware about their availability and where to access such funding and support (either from local authority or charitable organisations).

Victims of domestic violence are doubtless to suffer from the effects of space constraints and the disruptions to their connection to the outside world. The severance of social relations and opportunities to reach out caused grave adverse consequences to their physical and mental wellbeing. A caring, solidaristic approach entails appreciating the necessity for them to leave their current confined space and be in a safer space with adequate support. Critical, uninterrupted multilevel support during lockdown in this area must be ramped up to provide interventions to support them. While the victim needs to take action, others who are in solidarity with them such as neighbours or friends in the community can take action. Examples of solidaristic caregiving in this situation include being alert to situations where people are prone to abuse and then alerting the relevant authorities. This requires concerted effort from all levels of communities, necessitating modifications to the way support is delivered during ordinary times so that caregiving is effectively rendered to the victims. Any broken links

in between will result in the continuity of helplessness and perpetuated abuse.

Working mothers, families and single parenting face additional challenges in negotiating their commitments during lockdown while continuing to experience diminishing mental wellbeing. It is crucial to be attentive to the fact that while the economically secured and resource-supported households can actively undertake self-care and community caring practices for their mental wellbeing through encouraging words, sharing their experiences online, or engaging in support group activities that signal collective, societal responsibility for the benefit of the community during difficult times, it is less likely to occur for economically-constrained households. For caregivers who have caring responsibilities for older parents, relatives or children, it is more crucial than ever that they can access external support for their mental wellbeing. Caring for them means being aware of the difficulties they experienced, the realisation that their social interactions are curtailed and the space they inhabit has now become confinement, rather than productivity and healing, with detrimental effect on their mental wellbeing. Community solidarity performs the role of standing up with them and standing up as one of them in helping them, either through childcare, prepared meals or counselling. Their support offer relief to working parents during lockdown. While community centres, employers, local authorities and charitable organisations can help, the circular effect on population mental wellbeing warrant the joint effort of multi-level organisations and sustainable funding.

It is clear that caring, solidaristic actions apply to all levels of population in addressing mental wellbeing challenges during lockdown and beyond. Promoting and maintaining mental wellbeing is a concerted effort from an individual level, interpersonal level to household and population level. The realisation that everyone is experiencing the effect of lockdown together reminds us of the importance of solidarity and care. It motivates us to re-evaluate certain assumptions we hold, and encourages us to play a part in caring for people through solidaristic actions. By understanding the sources and factors affecting mental wellbeing, we can provide meaningful, ethically responsive care to people.

Conclusion

This article has outlined the significance and implications of lockdown on mental wellbeing precipitated by COVID-19 from the perspectives of space and social relations. Lockdown has disrupted norms about homes,

spaces and social relations, and replaced with renewed perspectives about their interactions on the mental wellbeing of the inhabitants. Space is experiential and relational for the inhabitants and our mental wellbeing. The totality of mental wellbeing thus needs to include the space we inhabit and the social relations forged within it. Daily interactions and routines chart our experiences with the world, other people, and influence our emotional responses, which feeds into our perceptions of wellbeing. A socio-spatial analysis of lockdown reveals important areas where mental wellbeing is subject to additional vulnerability and how care ethics and solidarity can perform an effective, ethical role in addressing mental wellbeing challenges in a pandemic. The relationship between solidarity and care ethics is underpinned by relationality. As human beings are relational in nature, solidarity and care offer a practical framework in providing contextualised and responsive caring actions based on a local understanding of mental wellbeing.

Lockdown has transformed the way we live and urged us to rethink our priorities, limitations and abilities. It has, most importantly, revealed how societies are galvanised to reach out and care for each other during shared periods of crisis. It has also provided policy makers the opportunity to identify and chart the effects of the pandemic on mental wellbeing over a life course, in preparation for the future. Although lockdown will be a memory one day, its consequences affect us in various ways. It encourages us to reflect on possible ways in which COVID-19 shapes the understanding of mental wellbeing in the future. When the next pandemic strikes, the hindsight from this pandemic will help us manage our mental wellbeing better and in a more responsive, kind and caring manner. The pandemic has shown us the ways care and solidarity can mediate mental wellbeing tensions in response to isolation and redefined the relationships we have with our self, the space we inhabit and our relations with or towards others. Understanding mental wellbeing from these perspectives enables us to care in a context-sensitive and responsive way.

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