

Aloneness and loneliness – persons with severe mental illness and experiences of being alone

Gunnel Andersson^{a*}, Anne Denhov^b, Per Bülow^c and Alain Topor^b

^aFoU-Södertörn, R&D, Stockholm, Sweden; ^bDepartment of Social Work, Stockholm University, Stockholm, Sweden; ^cDepartment of Psychiatry, Ryhov County Hospital, Jönköping, Sweden

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People with severe mental illness (SMI) are often described as lonely and socially incapable – an inability resulting from the mental illness. The aim of this article is to explore experiences of being alone among persons with SMI. The article is based on interviews with 19 persons diagnosed with psychosis who were interviewed between four and nine times over a period of three years. The findings show that experiences of being alone can be identified by *two* concepts: aloneness and loneliness. The persons in the study appeared as socially able and active in relation to their social lives. However, a social agent does not operate in a void but in interaction with specific living conditions; the experiences of aloneness and loneliness may be viewed as the result of the interplay between the individual and the social and material environment.

Keywords: aloneness; loneliness; severe mental illness

Introduction

People with severe mental illness (SMI) are often described as lonely and isolated (Harvey and Brophy 2011; Nilsson, Lindström, and Nåden 2008), and research also shows that people with SMI often have small social networks, dominated by family members and professionals. In studies where in-care patients are compared with ‘normal populations’, it emerges that the patients’ social networks contain fewer contacts and are more likely to be family-dominated (Becker et al. 1997; Bengtsson-Tops 2001; Hokanson et al. 2004; Pinfold 2000; Tolsdorf 1976). There is, however, research that shows a more varied social situation: even persons with SMI can have a social life that includes reciprocal relationships outside the family (Andersson 2009; Pickens 2003).

This article is based on interviews with 19 persons diagnosed with psychosis. In all, the result shows that their social lives have considerable variation. There are persons with a rich social life, with friends, family and partners, and there are persons with few social contacts. Some of them are lonely and longing for social inclusion; some are alone but not feeling lonely. There are, in brief, a great number of different experiences of social lives. The focus of this article is the experiences of persons with few social relationships.

There are various explanations as to why people with SMI may have few social relationships. In the body of research on this matter, there is a dividing line between a medical and a social perspective, where the medical has its central focus *within* the

*Corresponding author. Email: gunnel.andersson@fou-sodertorn.se

individual, while the social emphasizes factors *outside* the individual and the interaction *between* the individual and the social and material environment.

In a literature review of the phenomenon of loneliness among persons with SMI, it is stated that there is a lack of research on specific studies of loneliness. In existing research, loneliness is indirectly addressed as a result of psychiatric problems (Nilsson, Lindström, and Näden 2006). Similar social situations like loss of social relationships and loneliness can also be found in other groups in society, for example, long-term unemployed. The last part of the introduction highlights research from connecting fields.

A medical perspective – within the individual

The medical paradigm offers individualized explanations as to why persons with SMI may have few social relationships. The social situation is here related to ‘the disease’ or ‘the disturbance’ and its effect on the individual and the individual’s social ability. To suffer from SMI implies impaired social ability and thereby withdrawal from social contexts and situations. This impaired ability affects the possibility to create and to maintain social relationships (Bejerholm and Eklund 2004; Bengtsson-Tops 2001; Friedrich et al. 1999; Hokanson et al. 2004; Nyström, Dahlberg, and Segesten 2002). Descriptions of persons who are diagnosed with schizophrenia and other psychotic conditions, as well as psychiatric instruments for diagnoses, contain criteria such as difficulty expressing oneself, lack of social interest and no desire to communicate with others, inability to create close relationships, etc. (Andreasen 1984; DSM IV 2013). The picture emerging is that of a socially uninterested and socially incapable individual.

A social perspective – the individual and the environment

In the field of social research, other aspects connected to having few relationships are emphasized that originate in the interplay between the individual and different environmental factors. One factor is the withdrawal of *other* persons when the relationship becomes too demanding and too one-sidedly supportive (Winer et al. 1981). The repudiation of others has also been connected to the negative attitudes towards persons suffering from SMI, caused by the definition of the problems as an illness. To regard people with problems as *ill* generates a process of stigmatization – and thus denunciation (Brea 2005; Scheff 1966). Obstacles to establishing relationships are connected with the *internalized* social stigma, originating from repeated experiences of becoming rejected by others (Davidson, Stayner, and Haglund 1998). There are also studies showing that people with SMI themselves reduce their network size to avoid contacts that have a negative effect on well-being and mental health (Andersson 2009; Brea 2005). However, there are also other explanations for why persons with SMI may have few social relationships. Erdner (2006) states that long periods of hospitalization cause the individual to end up outside social arenas. Also Pinfold (2000) points out that a lack of arenas for social interaction has an impact on the characteristics of the social networks (i.e. that they contain few contacts) and loneliness over long periods of time. A lack of possibilities to create meaningful relationships outside the domains of psychiatry has also been described by Davidson, Stayner, and Haglund (1998).

There is yet another factor ‘outside the individual’ that can be connected to having few social relationships; this is limited material resources. Inadequate economic resources influence the possibilities for social activities and social company (Barham and Hayward 1991; Davidson et al. 2001). People with SMI have often been poor for a long time and

have few possibilities to improve their economic situation. When it comes to persons with SMIs, this is an often overlooked obstacle to possibilities to attend social arenas and meet other people (Topor et al. 2013) but has been highlighted in other areas, for example, long-term unemployment (Jönsson 2003).

Having few relationships – often associated with persons with SMI – have also been found by unemployment research. Westerholm (1996) states that long-term unemployment results in a loss of close relationships. Moreover, Jönsson (2003) found that fundamental social needs such as socializing and exchanging experiences with people outside the core family disappear. Two British researchers stated that devastating loneliness and social isolation – which are often found with mental health patients – are also conditions connected to unemployment or loss of a spouse (Barham and Hayward 1991).

But it is not only the long-term unemployed who share living conditions with persons with SMI. Negative social consequences, in both the short and long view, also affect, apart from patients with psychosis, persons who have been treated for physical diseases such as stroke, cardiac infarction and certain forms of cancer. Among those who have been hospitalized for those different diseases, low income, social welfare, weak connection to the labour market and separations are more common than among those who are not ill (Socialstyrelsen 2010).

Different possible explanations for why persons with SMI may have few social contacts have been presented. The medicalized orientation highlights a picture of the socially incapable individual, while the social orientation stresses the relationship between the individual and the social and material environment. Research connected to groups with related living conditions underpins the social orientation.

The aim of this study is to explore experiences of being alone: what factors seem to have an impact on becoming alone and how people with SMI experience being alone?

Method

This qualitative study, based on interviews with 19 persons with SMI, is part of a larger register study, including 1501 persons diagnosed with psychosis.¹ The inclusion criteria were (1) a psychosis diagnosis sometime between 1997 and 2004 and (2) contact with a psychiatry ward during 2004. A strategic sample of 19 patients gave their informed consent to participate in the interview study. The variables used in selecting persons for the interviews were gender, age and length of time they had been in contact with the psychiatry ward. These variables allowed the creation of as heterogeneous a group as possible (Topor et al. 2012). The interviewees were selected by professionals at the local outpatient care centre. The research was approved by the Regional Ethical Vetting Board (EPN) in Stockholm, Case # 2005/2:1 and Case # 2009/806–32.

The interviews were conducted at a venue chosen by the interviewees, usually in the respondent's home, but also at the research office, cafés or at a care unit. The 19 subjects were interviewed between four and nine times over a period of three years. In all, 97 interviews were conducted. The interviews lasted 1.5–3 hours. All interviews were tape-recorded and transcribed verbatim. All identifying information was deleted and the names were changed. In all, the collection of transcribed interviews consists of 2500 pages.

The main purpose of the interviews was to follow the course of the respondents' everyday life as closely in time as possible to when events occurred. Two aspects of their daily life were in focus: the challenges and social consequences of living with a psychosis

diagnosis, and the respondents' experiences of psychiatric and social services. The interviews were open with four themes forming the structure:

- evaluation of interventions provided by formal actors;
- information about and evaluation of interventions provided by informal actors;
- coping strategies; and
- everyday life and social relationships.

Four researchers (three women and one man) conducted the interviews and regularly met to discuss emerging themes. For this article, the first author read-through each interview and highlighted all parts that referred to experiences of being alone. During this phase of analysis, the researcher discovered experiences that could not be included in the concept 'loneliness', whereas the concept 'aleness' was found to cover all the experiences of the individuals. For each interviewee, a new document consisting only of the excerpts regarding these experiences was created. In the next step, these new documents were analysed by codifying these experiences. Categories that emerged were 'taking care of oneself', 'avoiding persons and places', 'breaking up', 'preferring being alone', etc. Core themes that developed were 'to deselect', 'to get deselected', 'wanting but not getting', 'never had' and 'not wanting'. The categories and core themes that emerged were continuously compared using the principles of grounded theory (Glaser 1998). Both the coding and the emerging categories were discussed repeatedly with the co-writers and in seminars within the research group to avoid researcher bias.

The participants

Of 19 persons, 10 were women and nine were men. Their ages were from 20 to 69, but most of them (12 persons) were between 30 and 49 years old. In all, 15 were unemployed and living off social welfare or pensions, three were employed and one person was a student. Almost everyone – 16 persons – lived in accommodation of their own, mostly rented flats, and three (one man and two women) stayed in group homes or residential care. When the interviews started (2006), the years since the first contact with psychiatry varied between 2 and 36 years.

Ten out of the 19 interviewed had extensive social lives, including both family of origin and/or family of their own and friends. Two of those persons still had experiences matching the theme of this article. The rest had experiences from being alone. In all, this article is based on the experiences of 11 persons.

Limitations

The persons interviewed were selected by professionals from the local psychiatry outpatient care centre. Although the research group could specify special requests such as age, gender and experience of a psychiatry ward, the final decision on whom to ask was made outside the research group. This could have implications on the findings, for example, more persons with good social skills may have been asked to participate than persons with problems communicating. There is a possibility this could have affected the reported experiences of social life. On the other hand, it is clear that all those interviewed had substantial experience of psychiatry wards and all of them had received a serious psychiatric diagnosis – psychosis – prior to the interview. Another limitation is the lack of ethnic variation among the participants.

Results

The aim of the study was to explore experiences of being alone: what factors seem to have an impact on becoming alone and how people with SMI experience being alone? One of the findings, connected to the experiences of being alone, is the need to use two different terms. Loneliness is, by definition, connected to a lack of social relationships and seems to be the term most often used when it comes to social experiences of persons with SMI (see for example, Nilsson, Lindström, and Nåden 2006). In order to embrace the experiences of the interviewees in this study, there is a need for another concept alongside loneliness: aloneness. This concept describes the absence of social contacts but is not experienced as a problem, whereas loneliness is an experience of lacking desired relationships (Perese and Wolf 2005; Weiss 1973). While aloneness is considered to be more of an unproblematic state, loneliness is defined as an unwanted situation (Heinrich and Gullone 2006).

The factors leading to loneliness and aloneness are presented in the next part under the following themes: *to deselect, not wanting, to get deselected, wanting but not getting* and *never had*. The first and second themes involve an active reduction of social contacts, emphasizing aloneness but may include loneliness, whereas the third and fourth themes are more distinctively connected to loneliness. The fifth theme – *never had* – may involve both loneliness and aloneness.

To deselect

One way to diminish social contacts is to actually deselect people. This was done for different reasons among the interviewed.

Karin said in an interview session that she was socially active and had several friends that she socialized with. She was never alone if she did not want to be:

I usually see people at weekends, but sometimes I don't feel like it – 'No, now I want to stay at home and watch TV'. But more often I get together with a friend and eat dinner, do something, go to the cinema or sit and talk, that's the usual stuff. I don't feel lonely, and I always have someone to call, and if I want to do something most of the time I will find somebody to hang out with.

On another occasion, later on, Karin said she had been 'feeling down' and that it had affected her social life:

I've been quite alone these past six months, I haven't felt like seeing anyone. It's not that I have become more lonely than I was before, it's more that I've been feeling down and haven't wanted to see anyone.

Karin did not *want* to socialize during a period of 'feeling down'. This partly reflects that she had choices – her temporary state of being alone was in a sense self-imposed – and can also be seen as an act of enhancing well-being.

Several of the persons interviewed described what happened to them socially when they had a mental crisis; one did not simply have the energy to be social. Hans said that all his energy was needed to concentrate on 'being a person':

So when it happens, this thing that happened that summer, the psychosis, it is such an enormous amount of work just to stand up on your legs and be a human. You lose the energy to contact your friends and be social.

To deselect social contacts can be seen as a way to concentrate on oneself and manage problems connected to periods of mental hardship.

Anna said she was forced to deselect her friends. This was partly because they could not fully understand what had happened to her and partly because she, like Hans and Karin, had to concentrate on coping with the most basic tasks of life during periods of mental hardship:

Anna: I got ill in such an overpowering way, so I had to break with my friends because they did not understand at all, they didn't understand what was happening, they thought it was really weird that I couldn't work...

I: You didn't get any support from them?

Anna: Maybe I could have got support, but I had to choose. I didn't manage to socialize, I didn't manage to ride the bus alone, I couldn't take the subway alone. I simply deselected them, I couldn't ... and that's what is a little bit boring now, that I don't have that many friends. It has been very difficult to re-establish the contact again, so to speak. I was ill for a year, but when I got well again I finished my education.

When Anna, after a year, resumed parts of her life, it was difficult to resume the relationships with her friends. Despite this, Anna kept in touch with some of them, but they did not have very much in common anymore. While Anna was living alone, her friends had developed other lifestyles:

I have a few friends left, but they've all had time to have families and kids and that's what's important to them now, and since I haven't succeeded with that, or how to put it, it hasn't happened to me, we may not share the same interests and aspects of life as we did when we were young.

Anna said that friends disappeared when the living conditions got so different that what was once unifying no longer existed. Here, then, is a 'double' model of explanation as to why social life changed. On the one hand, Anna deselected her friends in order to cope with her psychosis and because they did not seem to understand her experiences of mental illness. On the other hand, one could say that the friends deselected Anna as well in that particular situation. Thus, a mutual deselection took place. On top of that, there seems to have been a mutual 'sliding away' over time, reflecting the differences in life situations that have developed between Anna and her former friends.

Another way to reduce social contacts is to break up with friends or family members to avoid relationships that are a threat to well-being and mental health. Tomas broke up with one of his friends:

He blew me on six or seven thousand that I didn't get, so I broke up with him. A real mate doesn't do a thing like that. If he does, he's not a real mate.

To deselect can also be about deselection of specific contexts, such as mental care environments and the persons there, i.e. other persons with mental problems. A social context that during a certain period of life seems self-evident and supportive can at other times seem shackling and obstructive. One no longer wants to identify oneself with other persons with SMI.

Daniel was attending a social club for many years:

I got so tired of all those sick people, sitting there, staring at the ground. ‘What the hell, wake up!’ And if I don’t make conversation, they just stay quiet. I got so tired of that, I freaked out and said: ‘I’m leaving now’. But it’s not like I have something against people that are ill, that’s not it. There are some really nice people there but I just couldn’t cope with it. I wanted to do something else, something worth something to me. I felt stuck at that place.

Deselecting can also be about choosing something else instead of the company of other people.

Hans had neither enough time nor was he sufficiently motivated to maintain relationships with friends or partners. Moreover, it was not particularly easy for him to engage in relationships:

But anyway, she [girlfriend] was not so much in love with me actually, I don’t think so. I don’t believe that she had strong feelings for me at any time, but I have sort of hooked myself on to her and she has taken me on nevertheless, one can say. So I’ve gotten some closeness and that has been very positive for me, because I’ve always been ... it’s not easy for me to get close to people. I am totally convinced that you can’t live isolated, it doesn’t work, you must have people around yourself, but my dilemma is that I sort of can’t ... well, what should you call it ... I just want to work on my project.

To summarize, deselecting other persons can be an act to enhance well-being during periods of mental hardship, sometimes leading to mutual exclusion. Deselecting can also be an act to enhance well-being in response to having ‘no good’ relationships or social contexts and, finally, an act of choosing something else in preference to social involvement.

Not wanting

‘Not wanting’ includes persons called ‘loners’ – persons who never had many friends but also those who cultivate this aspect of aloneness later in life.

Erik had a job and he had workmates, although in many ways it was a single-handed job. In his spare time, he sometimes socialized with his brother, but a large portion of his life was spent alone:

I am a ‘lone wolf’ and I’m happy with that. I like to be alone, it’s as simple as that.

Erik had lived with a woman before, but had been single for several years:

No, I don’t miss that life. Now, I need only to think of myself. If you’re a couple you have to conform to one another’s wishes, you have to give up a part of yourself. No, I’m damn pleased with my life the way it is, no doubt about it.

Magnus, who lived in a residential home (but with his own little flat within the residence) and was surrounded by professionals and other persons with SMI, enjoyed being alone in his apartment. He wished he could get out of the social obligations (meetings, dinners and so on) connected to the residential situation. Magnus had frequent contact with his mother, and during periods of his life there had also been friends, but he could probably best be described as a solitary person, a lone wolf:

I enjoy being alone, it doesn’t bother me. I don’t have to be with someone else or to have people around me. I can sit here in my solitude for hours, turn on the radio, drink coffee ...

To get deselected

A more problematic aspect of deselection is to *get* deselected by others. This experience is, in this context, drawn from seeing others having insufficient time for social contact.

Irène had children, grandchildren and a close friend, but described how a feeling of loneliness was emerging in relation to her social life: the everyday lives of her family and friends seemed so time-consuming, so full of activities and meaning:

Before, I often went out in the woods all alone, I was very often alone, but I didn't feel lonely. But now I've noticed something that strikes me very hard, and it's about being a burden. People explain all the time how busy they are and how much they have to do and that they don't have time for me. And I notice this everywhere. I notice it with my children, and I notice it with my friends – not so much with my brothers and sister because they don't live around here – but even with my very best friend I notice how she says: 'I can't call you so often anymore' because she's going to work now. She's been unemployed for a long time, and of course it's great that she will start working again, but all of a sudden she has not time for me at all. And this thing, that nobody has time for me, and that I must beg for social companionship with people, has hit me very hard. This has really changed to something negative, that nobody asks when I'm coming home and nobody really cares about me. And then this feeling of meaningless arises ... I know it's dangerous, the feeling of meaningless, that nothing matters.

Irène was often quite alone even earlier, but she did not feel lonely: she was in demand as a wife, a mother, a grandmother and as a friend. Her life changed when she became a widow and her unemployed friend, with whom she had shared an 'everyday life without working', got a job. Her family and friends had lives of their own; they did not have time to socialize and a social imbalance appeared between Irène and those she cared about.

Wanting but not getting

Relationships must be 'made' and maintained somewhere and lack of social meeting places and contexts is a theme in several interviews, often intimately connected with a lack of money.

Klara was longing for friends and for love but felt trapped in her apartment, with very limited economic resources to convert her social longing to social places. She would have loved to go out to public arenas such as pubs and restaurants. It was hard for her to stand the loneliness:

You are like alone all the time. I'm alone in my apartment and I'm alone when I sit at the unemployment office, and the only persons I see are my mum and sometimes my only friend. It's not enough, I need a bigger and more solid contact network.

There was an apparent link between the possibility to enter 'public spaces' like restaurants, pubs, cinemas – and the economic situation. Lack of money was a crucial obstacle to entering social environments:

It's not only about the money. It's about status, social status. If you have a job where you are appreciated and successful, you get an entirely different status, and you emanate self-confidence that makes people drawn to you, people get interested in you, want to find out who you are and what you think and so on. But if you appear as a bloody loser and think 'I have no job, I have no money, I have no health, I have no sense in my head ...' then it's, of course, meant to fail. You might as well go to bed....

It was not only the money in itself that constituted an obstacle for Klara. It was also about what money represents – a job and status. No money – no status. Who would Klara present herself as? Deficiency of money and status was preventing Klara from having a proper social life; poverty and self-presentation seem interrelated.

Never had

Some of the interviewees said that they had never had many friends. There were no relationships to deselect or ‘lose’ in connection with experiences of SMI.

Hans was bullied during his childhood and linked the difficult social situation he had then, to those difficulties he currently had when it came to making friends:

And I notice, even to this day, how hard it is to relate to people because I’ve been let down all my life ... that’s how I feel, and I begin to understand a little what it’s all about, I begin to realize that I have problems making friends.

For Hans’ part, the social difficulties had continued as an adult and after he was diagnosed with psychosis. At the same time, he did not wish to have too many relationships – they intruded on his creative work. Klara had similar experiences:

The thing is, when I think about it, I always had problems relating to the social environment, I was bullied during my entire childhood, both as a child and as teenager, and also as an adult I have sometimes felt a bit pushed aside. It has affected me as a person and it still haunts me to this day I think. That’s the reason for my uncertainty, that I take nothing for granted and always think ‘yes, yes, we’re friends now but I don’t know what it’ll be like later on’. So I guess I have always felt quite unsafe.

In Hans’ case, the deficiency of relationships with friends had always been a part of his life. Klara, on the other hand, had had friends during periods of her life, but her negative experiences affected her self-esteem and her ability to make friends. The social insecurity they both felt as children was still with them and had become part of the self-image.

To approach other people and develop reciprocal relationships requires a certain trust in one’s own social capacity or in being a person who others simply want to be with.

A negative self-image can also be expressed by considering oneself as boring. The self-image of being boring and not having anything to say, nothing to tell, influences the desire and the opportunities to approach other people. Karin said:

When I meet people I often feel boring and that I don’t have anything to say. And then I’d rather be alone than go out and meet people.

To summarize, few social contacts can embrace experiences of both loneliness and aloneness. The more unproblematic aspects of being alone, captured in the concept of aloneness, are exposed in the themes *to deselect* and *not wanting* (avoiding or breaking up with persons and places or choosing something else besides social contacts), whereas a more problematic side is expressed in the themes *to be deselected*, *wanting but not getting* and possibly – but not necessarily – in *never had*.

The 19 persons in this study had all experienced the diagnosis of psychosis but had developed different social lives. SMI itself does not seem to be a predictor for what social life a person develops. Most of the persons interviewed had a social life with reciprocal relationships outside the family of origin – but there were other experiences as well. This

article has focused on experiences of social lives with few social contacts, leading to the use of both the terms ‘loneliness’ and ‘aleness’ to embrace the experiences of the interviewed.

Discussion

Persons with SMI are often presented as lonely – a loneliness emanating from their social inability caused by the mental illness (Nilsson, Lindström, and Nâden 2006). This picture can be called a cliché:

The picture, which I refer to as cliché, rests in on historically and culturally conditioned knowledge that limits the possibility to see persons with psychiatric disabilities as something other than passive, socially withdrawn and incurable, as a result of which other personal potentials disappear into the shadow of the cliché. (Grönberg Eskel 2012, 138; Translated by the authors of the article)

This stereotypical picture of persons with SMI is very different to the actual social lives of the interviewed. We would in this context like to apply the concept of *social ability*. Social ability can be described as knowing oneself as a person who is able to make choices, take initiatives and to perform in a world shared with others (Davidson 2006).

The picture of the socially unable individual, represented by the medical view on persons with SMI, stands in contrast both to earlier research in the social field and to the findings in this article. Earlier research of why persons with SMI may have few social relationships presented in this article have been assigned to the categories of ‘within the individual’ and ‘between the individual and the environment’. The findings of this article point towards an interpersonal – ‘the individual and the environment’ – direction, emphasizing the individual as socially able, as a social agent. However, a social agent does not operate in a void but in interaction with specific living conditions; the experiences of aleness and loneliness may be viewed as an interplay between the individual and the social and material environment.

The findings suggest that *deselecting* and *not wanting* social contacts are important themes. Deselection can be viewed as an act of enhancing well-being in relation to periods of mental hardship, specific relationships or specific environments. Not wanting is about preferring solitude. These aspects seem, to a large extent, to have been neglected when it comes to persons with SMI.

Being alone has been explained by the individual’s inadequate social ability and the withdrawal from social life as a consequence of serious psychiatric problems. This study embraces experiences of withdrawal as a result of mental hardship as well, but when it comes to identifying the reasons, this study points in another direction: people with SMI can be viewed as socially active in an actual *reduction* of their social contacts or by avoiding increasing them.

Part of this result has been established before within the field of social research, concerning withdrawal from persons having a negative effect on well-being and mental health. In an American study (Brea 2005), the author claims that social inability and theories of stigmatization have been overemphasized at the expense of regarding the individual as a socially active person in relation to his or her social relationships. This study, however, adds *additional* aspects of being alone and shows a variety of experiences, leading to both loneliness and aleness. There is a time aspect here as well. Withdrawal from social contacts does not seem to be a static condition but rather a

way to enhance well-being in *periods* of mental hardship. The method probably has an impact on this result; since the subjects were interviewed over time, change could be captured.

More problematic aspects of being alone are found in the themes *to get deselected* due to the lack of time of others, and *wanting but not getting*, emphasizing the lack of social arenas and the connection with lack of money. There seems to be a dependency between social relationships and social arenas: lack of social arenas leads to deficiencies of the prerequisites for generating relationships, leading to deficiencies in experiences of being with and talking to others.

Never had, as the last theme showing the variation of experiences, indicates experiences of persons who never had many friends, possibly connected to self-image (not being good or fun enough) or with a self-image of being a ‘lone wolf’. To get involved in ‘voluntary’ relationships like friendship requires a belief in one’s own ability to have something to give in return, to be ‘worthy’ of friendship. A stigmatized self-image probably influences whether or not one has the courage to get involved in relationships.

A unique life situation?

The persons interviewed had one thing in common – serious mental illness. And despite the fact that they lived various social lives, most of them had yet another thing in common: inadequate economic resources. The medical paradigm and its diagnostic culture convert social situations and experiences to signs of psychiatric illness. The diagnostic culture also throws a special light on the social circumstances of the individual, as if they spring from just one source – from the psychiatric illness. If we consider that persons with SMI often include people living under conditions such as long-term unemployment, benefit dependency and poverty, their life situation is revealed as not particularly special, but much like other groups in society with whom they share similar living conditions.

Since people with SMI often have little money, it can be interesting in this context to look at other financially vulnerable groups – such as the long-term unemployed – and how these circumstances affect social life and the possibility of entering social arenas. A study of economy, unemployment, health and social effects showed the poorer financial situation among the unemployed, the poorer health and lack of participation in social activities (Rantakeisu, Starrin, and Hagquist 1999). It was also established that there are two social needs that are difficult to satisfy when unemployed. One is money and the other is to become socially accepted (Jönsson 2003); unemployment itself can be stigmatizing. Deficiency of money and (thereby) lack of social contexts are two factors that have crucial importance on the social lives that can be developed, for both people with and without mental health problems.

Finally, in this study we have seen countless examples on how the interviewed persons relate actively to their social lives. People with SMI seem not to be passive viewers but rather *co-creators* of their lives. They shape their life trajectories *at the same time* as these life trajectories are shaped by living conditions reflecting political decisions and social norms that reveal what standards should be applied for people with SMI in the twenty-first century in Sweden.

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Note

1. The Stockholm Follow-up Study of Users Diagnosed with Psychosis (SUPP) is a prospective and naturalistic study of patients' everyday life and recovery/illness process. This study has been presented elsewhere (Topor et al. 2012).

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