MASTER THESIS

Loneliness and Solitude in People with Psychosis: An Exploration of Experiences and Perspectives through Narrative Analysis

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Abstract

Purpose: Loneliness is prominent in individuals suffering from psychosis and has been associated with decreased well-being and quality of life. This study aimed to better understand the perspective of individuals with psychosis and how they experience loneliness in the course of their illness and during the recovery process. **Method:** Three autobiographical books, written by individuals who suffered from psychosis and recovered to differing extent, were analysed using narrative analysis. **Results:** The analysis revealed that loneliness was present in all three cases, often as a negative emotional experience. Other main findings included positive effects of loneliness and solitude, connection of stigma and loneliness, and identity processes in recovery. Two cases demonstrated beneficial effects of aloneness and feelings of loneliness. Loneliness was found to help in the process of accepting illness and engaging in treatment. Similarly, solitude facilitated reflection and served as a function of identity reconstruction. Furthermore, it was shown that stigma, in particular internalised stigma and stigma-related shame, was highly relevant to the construction of loneliness. Another finding was that loneliness and recovery were closely linked to identity processes. Assimilation of psychosis into the identity was shown to be important for recovery and subsequent reduction of loneliness. **Conclusions:** Overall, the findings of this study challenge the notion that loneliness and social withdrawal are purely negative in the context of recovery from psychosis and highlight its positive aspects, such as identity restoration and motivation for change. Additionally, this study showcases the value of narrative analysis and considering the research value of autobiographical accounts compared to more traditional qualitative data sources, such as interviews. Future research should further investigate the role of loneliness and solitude in the recovery from psychosis, as well as the meaning assigned to stigma and identity processes by afflicted individuals.

Keywords: psychosis, loneliness, recovery, solitude, stigma

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Social connection has been called one of the most fundamental needs of human beings (Cacioppo et al., 2014). One might argue that social connection is important to us because it ensures that our other, more prominent needs, like food or safety, are being met. However, research shows that social cues can activate the same reward mechanisms in the brain as food or even money (Tomova et al., 2021), emphasising the role the social dimension plays. A review by Cacippo and Hawkley (2009) asserts that perceived social isolation, or loneliness, is detrimental to the functioning of humans. They present loneliness as a major risk factor for cognitive decline, depressive cognition, cognitive negativity, and overall higher rates of morbidity. Fulfilling our social need seems to be an essential motivator and part of a healthy human life.

Definitions of loneliness vary widely in complexity and nuance. Some researchers have described loneliness simply, as a negative emotional response to social disconnection (Peplau & Perlman, 1982) Others have made several distinctions and constructed different levels of loneliness (Nilsson et al., 2006). Weiss (1973) distinguished between emotional and social loneliness. Social loneliness refers to a lack of a social network, like a broad range of friendships. Emotional loneliness describes a lack of intimate closeness in social relationships and is connected to feelings of emptiness and depression. These types of loneliness are distinct, in that fulfilling one of them does not necessarily fulfil the other. This more nuanced perspective shows how a simplistic view of regarding loneliness as an emotional response to "social disconnection" misses subtle distinctions within the experience of loneliness. When viewed from the outside, a person may seem very well be connected socially, and would thus not be considered lonely. However, if there is a lack of intimate connection, even a person surrounded by other people may experience a sense of loneliness. This aligns well with a study by Gilbert and Herbst (2014), which found that feelings of loneliness predicted cognitive dementia onset, not social isolation. Moreover, a meta-analysis by Masi et al., (2011) found that interventions aimed at changing maladaptive social cognitions of others had better effects on loneliness than merely increasing social contact. This further supports the notion that feelings of loneliness are related to the internal experience of individuals, not only to their external social environment. In general, loneliness appears to be constructed as a negative experience. It also does not seem to refer to "being alone" in general, as being alone can also be connected to positive experiences like solitude, which can even be sought by individuals

(Nilsson et al., 2006). These different conceptualisations suggest that there are potentially many different layers to the experience of loneliness.

Individuals especially afflicted by feelings of loneliness are those suffering from mental health problems (Badcock et al., 2020). One of the most debilitating conditions that can affect mental health is psychosis, characterized by several symptoms like distorted perceptions, beliefs, and thoughts (American Psychiatric Association, 2022). Individuals suffering from symptoms of psychosis often experience long-lasting impaired social functioning (Simonsen et al., 2010). For instance, individuals diagnosed with schizophrenia may have difficulties in navigating social interactions and building connections with others, which can be attributed to impaired social skills (Mueser et al., 1991). This is unfortunate, as having a well-established social network has been suggested to be important for individuals with chronic illnesses (Sias & Bartoo, 2007). Additionally, stigma can lead individuals to feel excluded from others and is associated with feelings of loneliness (Burke et al., 2016; Michalska Da Rocha et al., 2018). Thus, people living with psychosis often experience significant difficulties in their social relationships, which can have a profound impact on their overall well-being and quality of life (Badcock et al., 2020; Huckle et al., 2021; Morgan et al., 2017).

In general, it can be said that there are a variety of factors that play a role in the loneliness of individuals with psychotic disorders. Research seems to indicate that social networks (SN) are generally helpful for people suffering from psychosis, as they can help connect people to resources, give them information about their illness, and help them manage their symptoms (Pinto, 2006). Maintaining and developing social relationships is especially important to counteract feelings of loneliness. Loneliness has been shown to be a common experience for people with psychosis (Badcock et al., 2020). Lim and Gleeson (2014) stress that while it may be difficult for individuals with psychosis to find and engage in positive social interactions and build strong relationships, it is still possible and can help reduce feelings of loneliness. A systematic review by Wang et al., (2018) found multiple longitudinal studies which indicate that perceived social support by people with mental health issues like depression, schizophrenia, or bipolar disorder, correlates with better outcomes in terms of symptoms and social functioning. For schizophrenia specifically, social support correlated with higher levels of life satisfaction.

Despite the plethora of research indicating the detrimental effects of loneliness in psychotic disorders, there are also indications that not all forms of "loneliness" or "aloneness" are negative. In fact, what is called "solitude" can be very beneficial for individuals. According to Long and Averill (2003), solitude can lead individuals to feel a sense of freedom, creativity,

self-transformation and even, paradoxically, feelings of deep intimacy. Moreover, solitude is not only good for healthy individuals of the general population, as people with psychotic disorders may also reap some of the benefits. A study by Corin and Lauzon (1992) using qualitative and quantitative analysis on interviews of schizophrenics found that what they termed "positive withdrawal" was negatively associated with re-hospitalisation. Some participants who engaged in positive withdrawal expressed how it helped them create a sense of peace in themselves. Perhaps paradoxically, creating this calm internal space is even described as a prerequisite for connecting socially at other moments. Interestingly, this points to an odd link between solitude and social engagement. In the words of Corin and Lauzon (1992), it could be referred to "relating with distance", describing a unique perspective of a social experience, entertaining both social connection and separation. A review of qualitative studies on this subject by Sells et al., (2004) further illustrates the dynamic between solitude and positive withdrawal and the recovery of self within schizophrenia. They express how recovering the self as an active social agent is a crucial component of managing the negative effects of schizophrenia.

Focusing on the role of loneliness in the lives of people with psychosis is important, as it appears to be an essential factor in the emotional problems. As has been discussed earlier, there are different types of loneliness and as a concept it is not as simple as it may seem. There is both social and emotional loneliness, and loneliness does not necessarily correlate with being alone, as it is an internal experience that can be present even in rich social environments. Knowledge about the loneliness of people with psychosis makes it possible to design interventions to counteract it. And knowledge about the role of solitude in the process of recovery from psychosis may help in identifying ways to make use of it, without leading to the negative effects of social isolation. Some interventions focus specifically on loneliness. For example, a digital intervention tested by a small pilot study by Lim et al., (2020). Because loneliness has been shown to be a challenge for people with psychosis, the purpose of this intervention was to increase feelings of social connection. The intervention had promising effects and was accepted by most users. It follows that interventions focusing on this specific aspect of the afflicted population are useful. A systematic review by Lim et al. (2018) stresses a shortage of interventions focusing on loneliness, as well as a lack of research attempting to understand the role of loneliness in psychosis. While several reviews uncover associations of loneliness with other factors (Badcock et al., 2020; Wang et al., 2018), there is a lack of studies that consider the details of how individuals with psychosis experience and deal with loneliness in the course of their illness (Lim et al., 2018). A detailed and extensive understanding is

important, because otherwise it is difficult to design successful interventions targeting the specific issue (Michie et al., 2011). For instance, considering that there are different layers to the experience of loneliness (Weiss, 1973), an intervention which is designed without knowledge of these different layers may only target one aspect of loneliness, while omitting other aspects. Additionally, interventions may overlook positive aspects of loneliness or solitude. To uncover the details of the experiences of individuals with psychosis, a qualitative research method is required. A meta-synthesis by McCarthy-Jones et al. (2013) illustrates the value of conducting qualitative research on psychosis. They emphasise how an inductive qualitative approach, using rich, in-depth data, is ideal for exploring the perspectives and lived experiences of people with psychosis. They synthesised four emerging themes across 97 articles: “Losing,” “Identifying a need for, and seeking, help,” “Rebuilding and reforging,” and “Better than new: gifts from psychosis,”. Discovering important aspects to an illness like this is why qualitative research is so important, especially in a debilitating mental health problem like psychosis. The last theme "Better than new: gifts from psychosis", alluding to positive aspects, is something one might not expect, but is something that can be uncovered through qualitative research.

In terms of loneliness, there is one recent qualitative research study that used semi-structured interviews to find themes related to loneliness in people diagnosed with schizophrenia spectrum disorder (SSD) (Ludwig et al., 2022). Participants shared how relationships lacked depth, frequency of contact and changed overall over the course of the illness. The interviewed individuals seemed to especially miss the presence of a romantic partner. Most participants indicated that their best coping strategy is sharing their troubles with a trusted person. A new finding of this study is that individuals with psychosis experience both appreciation and frustration at relationships formed based on similar mental health problems, as they can be filled by empathy due to similarities, but also disrupted by hospitalisations and intensification of the illness. Bringing to light these aspects of the illness is extremely valuable, as it can help in developing more inclusive types of treatments and interventions, or at least inspire further research into the newly discovered dynamics. While this study addressed several important aspects of the experience of loneliness, Ludwig et al., (2022) state that their findings may be limited as the interviews were conducted close to the coronavirus pandemic, which might have influenced the overall experience of loneliness. The themes also seem to refer to contributors of loneliness, not different types of loneliness and how they are conceptualised by the participants themselves. In other words, the themes are mostly descriptive. This present

study intended to extend the knowledge and understanding of loneliness in psychotic disorders using a different, more in-depth source of data and a more holistic form of analysis.

The current study's aim was to analyse autobiographical books using narrative analysis. There are multiple benefits to using autobiographical stories of individuals with psychotic disorders. As van de Bovenkamp et al. (2020) highlight, patient stories present a uniquely rich form of data, as they can be quite extensive and encompass rich internal diversity. This means that they often carry information regarding a person's entire life, enabling them to illustrate how perspectives change over time. As opposed to an interview, in which most shared information will concern the topic at question, autobiographies consist of information regarding a variety of facets of a person's life. This means that a more extensive pool of data can be regarded and considered in terms of the topic of interest, and it is less likely that important aspects and facets are missed. In addition, this study follows the approach of narrative analysis, which constitutes several advantages. Narrative inquiry is a methodological approach to research that acquires understanding of how people make meaning in their everyday lives, through the narratives they tell (Sharp et al., 2019). In this way it allows to put people's stories into a grander social, cultural context. It is therefore a holistic approach to data analysis and uniquely suitable for exploring the perspectives on loneliness of people with psychosis. The research question is as follows: "How do people with psychosis experience loneliness?". As discussed earlier, different forms of loneliness exist, like social and emotional loneliness (Weiss, 1973), as well as even positive forms of loneliness in the form of solitude (Nilsson et al., 2006). Acknowledging this diversity of a universal experience like loneliness was an essential component of the analysis. Naturally, theoretical frameworks like the one by Lim et al., (2018) and the findings of other qualitative studies like the ones by McCarthy-Jones et al. (2013), were considered in the analysis process of this study. This allowed embedding the findings of this study into the already established academic context. At the same time, the data was regarded as standing on its own, allowing for new insights to be gathered.

Method

Design

This study follows a case-based, qualitative research design using autobiographical books. It was conducted between November 2022 and August 2023. I chose several books as my source of data with various criteria.

Selection of Books

The books were identified from reviewing previous literature on the topic of this study, searching online retailers and library databases as well as by searching relevant keywords on online platforms such as Amazon, Google Books and Goodreads. The basic criteria for selecting books for sampling were that the autobiography included first-hand experience with psychosis and that the story encompassed an element of loneliness. Over 20 books met the criteria, but only three could be chosen due to time constraints. Of the autobiographies that met the criteria, to maximise variation, books were sampled that were not too similar to each other. For this reason, authors of different genders, ages and nationalities were included. One author is from the United States, one from Germany and one from Norway. The final sample was made up of the following three books: The Quiet Room: A Journey Out of the Torment of Madness" (Schiller, 1996), "'I' is sometimes someone else" (Winkler, 2019), and "A Road Back from Schizophrenia" (Lauveng, 2020).

Procedure and data analysis

For the analysis method, the storyline analysis method of Murray and Sools (2014) was followed. This method is divided into 5 parts and uses twelve steps during the analysis, which can be seen in table 1. Part 3 of this analysis method was omitted, because the data lack a clear interactive component. Furthermore, step 10 was omitted, as the wider social context was not relevant to the research question.

Table 1

Storyline analysis as devised by Murray and Sools (2014)

Part	Step
Part 1: Introduction	1. Formulate case title
	2. Introduce case
Part 2: Storyline Analysis	3. Formulate storyline title
	4. Identify and describe storyline elements and breach
	5. Write narrative summary of storyline
	6. Draw conclusions regarding your research question based on steps 3-5 and discuss your findings
Part 3: Interactional narrative analysis	7. Positioning of storylines
	8. Positioning of storytellers/listeners
	9. Conclusion and discussion of what is at stake
Part 4: Contextual analysis	10. Positioning of storylines in the wider social, societal and political context
	11. Positioning of storytellers/listeners and interactional patterns in wider contexts
Part 5: Contextual analysis of storylines, interactional patterns and/or contexts	12. Make comparison of similarities and differences between cases

The material was read in a general manner, taking note of the general structure and storylines of the text. Passages relevant to the research question were marked. Throughout the entire process, notes relative to the narrative analysis were taken to help in the process of developing an integrated understanding. Markings and notes, as well as repeated readings, were used to identify different perspectives within the self and to gain a holistic understanding of how these perspectives relate to each other. Through iterative reading of relevant passages, a view of the material was formed that could coherently unite the related themes. Broad categories were derived from the reading process and their interrelationships are examined. Due to using narrative analysis, a holistic rather than categorical approach was taken in the analysis process (Lieblich et al., 1998). As such, rather than categorising parts of text into overarching themes

using coding strategies, each individual life story was taken as a whole and interpreted in the context of its interrelated parts, plot lines and overarching meaning making and narrative (Wertz et al., 2011). This means that certain sections of the text that were relevant to the research questions were interpreted in the context of the entire life story. The purpose of using this more holistic approach and analysing how parts are connected and integrated into the underlying narrative, is to properly understand how the writers made sense of their experiences.

Results

This results section is structured in the following way. First, each book is analysed separately. The separate analysis includes an overall impression of the book, a summary, a storyline analysis of the different storyline elements present in the book, and a conclusion. After each book is analysed this way, a comparative analysis of all books follows.

1. Narrative Analysis: "'I' is sometimes someone else" by Cordt Winkler

1.1 Overall Impression

The story is permeated with descriptions of the narrator's inner experience and thinking, allowing for an immersion in his perspective. This makes the story feel like a diary entry that stretches over many years. While other people in the narrator's life are dealt with thematically, the focus always returns to the narrator's experience. The story details his journey through this disease and, most importantly, clarifies the difficulties it imposes on him and his life. At the same time, the protagonist, Cordt, does not go into the depths of his symptoms and does not question their origin beyond his biological affinity. Thus, the story is focused on his handling of the symptoms, their effects on his life and recovery and thus largely remains in a pragmatic paradigm, rather than veering off into philosophical domains. Therefore, the narrator appeals to a wide audience and gives off a feeling of relatability.

1.2 Summary

This autobiography follows the life of Cordt, a German man who developed paranoid schizophrenia at a young age while studying at university. Cordt had bad experiences with schizophrenia as a young child, because his father suffers from the same disease. The episodes and hospital stays of his father shattered Cordt's family life. There is a great deal of shame associated with his own illness, and his episodes embarrass him in front of his friends, despite their support. He has trouble talking about his illness and spends a lot of time alone. Several times he is hospitalized. He is being treated with medication, but keeps stopping the medication

due to severe side effects, which leads to frequent re-hospitalizations. His relationship with his father is distant at first, but with the onset of his illness, and through the time he once spends with his father in the same hospital, he grows closer to him. The illness seems to make him understand better that his father couldn't have had it easy. When his father dies, Cordt seems to have made peace with him. Codt eventually accepts his own illness as well, and due to his stable medication regimen, he does not suffer another episode for years. At the end of the book, he makes a solo trip to Italy, where, years ago, he had gotten lost for several days during a sudden paranoid episode, a traumatic time he can't even remember properly. In his solitude, he finds closure with this experience and makes peace with himself and his illness.

1.3 Storyline analysis: "I did not want to become like my father, and I didn't want to get this disease"

1.3.1 Agent. Cordt experiences shame for his father as a young child. "*I scrutinized the onlookers until I was relieved to realize that none of my classmates were among them. I felt ashamed. The whole scene was incredibly embarrassing to me*"(*C. Winkler - p.16*). Later, when he experiences symptoms himself, he feels ashamed of himself too and does not know how to talk to others about it. *"I didn't dare to talk to friends or anyone else about it. (...) It was difficult to describe the strange things that were brewing in my head. Apart from that, it was embarrassing for me" (C. Winkler - p.32).*

1.3.2 Acts and Events. The story begins with Cordt moving to Berlin, where he soon experiences his first episode during his studies, mainly paranoia and delusions. He gets on medication but is frequently hospitalised during the story, often because he stops taking his pills due to the strong side effects, sluggishness, and weight gain. Once he is hospitalised in the same hospital as his father, where they spent a lot of time together there and get closer. *"We had plenty of time to walk together over the coming weeks (...) Something seemed to have changed between us. In any case, I managed better to get involved with him." (C. Winkler - p88)*. His father later dies, which he feels sad about but copes with relatively well. His worst episode occurs during a holiday in Italy, where he gets lost for weeks. Upon returning to Germany eventually, he has big memory gaps. At the end of the story, he goes on an Italy trip alone in order to retrieve some memories and make peace with his situation. He is stable and uses medication at the end of the story.

1.3.3 Means and or helpers. His relationship to his father is one of the means for Cordt coming to terms with his illness. His father also has schizophrenia, which was very difficult and also embarrassing for Cordt as a child. After his father's death, he reflects on his

relationship with him. *"... I was better able to look at the positive things I owed him and to sort the numerous memories associated with the illness a little more benevolently. He had tried, as best he could, to be a good father to my sister and I, and it was within the last few years that I had managed to develop a good relationship with him" (C. Winkler - p.201)*. Eventually, the acceptance towards his father also represents his acceptance towards his own illness.

1.3.4 Scene and setting.

Cordt is moving between different settings frequently, which makes it difficult to pinpoint an overarching setting or scene. What is present throughout, however, is his focus on self. The text does not go overly into detail concerning the environment Cordt is in. Instead, the text often reads like a diary entry, filled with thoughts and internal experiences and reflections, which are mostly of a rational nature. This sometimes gives the story a perspective of detachment. Detachment from the surroundings and other people as well. Cordt seems to spend a lot of time alone in general.

1.3.5 Purpose. Cordt's purpose is largely to live as closely of a normal life despite his symptoms as possible. This is why he attempts several times to stop medications, as they produce severe side effects for him. His purpose seems to be not to become like his father.

1.3.6 Breach. Throughout the story, Cordt seems to have the purpose to not become like his father, which fundamentally represents his rejection of his illness. Thus, a conflict arises with the onset of his first symptoms. Shortly after the beginning of the prodromal phase, without having any diagnosis, he has the thought *"I did not want to become like my father, and I didn't want to get this disease" (C. Winkler - p.31)*. At the beginning he rejects his father, but at the end of the story he sees his father as part of him. *"I heard my own throat clear. My father's familiar sound. In that way, he was still with me." (C. Winkler - p.232).*

1.4 Conclusion

Shame plays an important role in Cordt's life. Being ashamed of his father starts at an early age. The desire not to be seen, to remain anonymous, perhaps also to be "normal", to be able to hide in normality, is very present. But with the onset of his illness, this is not possible. There is a gap between what Cordt had hoped for in life, with big dreams and visions, and what presents itself to him as reality. A battle with his illness ensues, and every time he suffers an episode, he is incredibly embarrassed. The desire to be able to lead a normal life, without paranoid thoughts, but also without the side effects of the medication, causes great frustration. Cordt's internalisation of stigma and the eventual letting go of stigma is connected to the same person: his father. While stigma is not necessarily connected to direct experience, Cordt

experienced the negative effects of schizophrenia on himself before he ever developed it himself. His family life was highly influenced by his father's condition. As such, at the beginning of the story and well into its middle, Cordt seems to be on a mission to not become his father. However, as he makes more and more psychotic experiences himself, he seems to be able to empathise better with his father's and his own condition. Especially his hospitalisation in the same hospital as his father seems to facilitate Cordt's perspective taking ability. After his father's death, he reflects on how difficult it must have been for his father. Cordt's story illuminates the dynamic of this illness when several family members are afflicted. Apparently, there can be both negative and positive aspects to such a family dynamic. Importantly, it seems that solitude is an important aspect of Cordt's story. Especially his withdrawal at the end of the story, where he takes his journey to Italy alone, can be interpreted as a regaining of his self and his autonomy. While his life had been disturbed and endangered by his illness for years, he finally comes to terms with it. Cordt's story thus emphasises how a sense of independence and withdrawal may not always be a sign of negative social isolation. It may also indicate an important aspect of a recovery process. A recovery of self.

2. Narrative Analysis of "The Quiet Room: A Journey Out of the Torment of Madness" by Lori Schiller

2.1 Overall impression

"The Quiet Room: A Journey out of the Torment of Madness" is a gripping memoir that pulls the reader into Schiller's world through deeply personal sharing. She openly writes about her most terrifying hallucinations, experiences, and feelings. Through this candid account of the perspective of a person with schizophrenia, the reader is able to delve into her world and empathise with her struggles. The book also highlights how the illness affects Schiller's relationships, how the people around her react and suffer with her, which makes the reading experience all the more dramatic and real. Despite the difficulties Schiller faces, she manages to inspire hope in the reader. Ultimately, the story is not about the victim of an illness, but about an incredibly strong woman who, with a lot of effort and character, takes back the life that fate had snatched from her.

2.2 Summary

This story is about the life of an American woman called Lori Schiller and follows her through her years in high school when her first symptoms of psychosis appear, until several years after her last hospitalisation. The story represents a stark contrast. Initially, Lori leads a

very successful life, gets the best grades in school, and speaks of good experiences and a close, loving family life. But everything changes with the onset of her illness, and suddenly she is a patient who goes from hospital to hospital and has made several suicide attempts. The worst symptom of her illness is the emergence of aggressive and terrifying internal voices. Despite the impairment she is experiencing, Lori cannot accept that she is ill. She struggles against her treatment and vehemently denies her sickness until she finally realizes that she really is ill and needs help. Coupled with the introduction of the first atypical drug, Clozapine, and her insight and hard therapeutic work, she manages to get her life back on track.

2.3 Storyline Analysis: "Perhaps I was sick after all."

2.3.1 Agent. The main character of this story is Lori, a young Jewish woman whose first symptoms of schizophrenia appear in her late teens. At the beginning of her life, she is above average, ambitious, gets good grades, is extroverted and playful. However, she undergoes a major change due to the illness, becomes withdrawn, moody, even aggressive. The aggressive, terrifying inner voices she hears isolate her and several times cause her to attempt suicide. *"I had to get away from these terrible, evil Voices. (...). 'You must die' they chanted 'You will die'" (Schiller, 1996, p. 16).* She is perpetually denying her illness and at the same time wants her old self back. She is constantly in a state of resistance, be it against her parents, the clinics to which she is often referred and their staff, and ultimately her illness itself.

2.3.2 Acts and Events. She hides her first symptoms, the voices, which start to appear when she is a teenager. She graduates from high school well, despite her symptoms, and goes to a prestigious college. Her condition worsens significantly after graduating from college, when she lives with a friend in New York. She attempts suicide and is almost admitted to a psychiatric ward, but her father manages to let the doctors take her home. After another attempt, she is eventually hospitalised. The symptoms are so severe, she is completely isolated and cannot even communicate, nor remember that first period in the hospital years later. After a while she can go home again, but she eventually attempts suicide again and is hospitalised. She decides to defy the doctors and nurses and listen to their voices instead. She behaves with rage, trying to escape, defying the rules of the hospital and her treatment. Several times she has to enter the "quiet room", a completely silent and empty room. This is supposed to be for reassurance, but she perceives it as torture and feels terribly lonely in it. At one point, the voices get so loud and horrifying in the quiet room that she punches a hole through the wall, revealing the bones on her hand. She seems so untreatable that the hospital is threatening to release her.

Although she's trying to escape all the time, she begins to realise that she might really need help.

She is transferred to a halfway house and goes to the day hospital. She begins to reflect a lot about her illness, and the more she realises how sick she is, the lonelier she feels. After another attempt, she is hospitalised, but this time she decides to be open to the treatment. She makes progress in therapy and gets much better. Then, she is prescribed clozapine when it is newly introduced into the American healthcare system. Her symptoms are greatly reduced with therapy and the medication, and she is eventually released and builds a life for herself, mostly free of the severe symptoms that had plagued her for years.

2.3.3 Means and helpers. For Lori, the illness itself and its symptoms, which draw her into an isolated mind space, seem to present a major factor in how she experiences her loneliness. At multiple points in her life, it seems that "the voices" do not let her connect to other people. *“When I heard the Voices yelling such terrible things, I grew afraid to make eye contact with the people I was with. (...). I began to feel that my friends hated me. That's what the Voices said." (Schiller, 1996, p. 28).* In certain situations, she is literally unable to attend to anything other than her auditory hallucinations. And of course, this makes a social relationship impossible. However, while loneliness is one of the negative effects of Lori's illness, it also plays a part in her recovery process. The fact of her being sick dawns on her only when she is unwillingly discharged from a hospital, as they find they could not help her anymore. A fact that she denies for several years, even after several hospitalizations. *"I firmly believed I was not sick, and did not belong in a hospital." (Schiller, 1996, p. 116).* It is in this period after her discharge, when she spends a lot of time alone thinking and reflecting, *"The more I began to realize I was sick, the more I became aware of the vast gulf separating me from everyone else, and the lonelier I became" (Schiller, 1996, p. 131),* that she makes a shift in perception and faces the reality of her sickness. Her realisation, enabled through a period of solitude and reflection, leads her to make a big effort and being open to her treatment for the first time. *"Those months living in the halfway house, spending lonely afternoons in a pastry shop watching the rest of the world live their lives, had convinced me that I was different from other people." (Schiller, 1996, p. 150).* Feelings of loneliness are a component in the turning point of the story, which is when it finally dawns on Lori that she is indeed sick and needs help. *"Perhaps I was sick after all" (Schiller, 1996, p. 128).*

Despite her isolation from others, there are important helpers on Lori's journey. The most consistent helpers in Lori's life are her parents. Nancy and Marvin Schiller are supportive of Lori in several ways, be it emotional or financial. They never turn hostile towards her and

visit her very frequently. Another important helpful relationship was that with one of her therapists, Dr. Fischer, at her last hospital. While before she barely shared anything about the voices she heard, she was able to write about it and share her writings with Dr. Fischer. Lori expects Dr. Fischer to be disgusted at her writings, but instead she is completely non-judgmental and grateful for Lori's participation in the healing process. This begins a habit of Lori to keep a journal, which helped her "bring some order to the chaos of my mind".

Another helpful means was medication. The medications she is prescribed along her journey show mixed results on the voices she hears, and they come with devastating side effects, like fatigue, concentration issues, weight gain and subsequent loss of self-confidence. However, when clozapine becomes available to her, the first atypical antipsychotic, her auditory hallucinations are for the first time significantly reduced. She notes that one of the most important effects of her new medication was "the return of something I hadn't realised was missing: I began to feel connected to other people.".

2.3.4 Scene and setting. A large part of the story takes place in hospital settings. Mostly, the settings seem cold and impersonal, which makes sense as Lori is unable to personalise significantly alter her environment. Additionally, the story as told by Lori generally does not include much information concerning the scene or aesthetic, which might be attributed to the internal focus of the story. Much of the story, after all, is focused on Lori's internal world and the interactions she has with other people. Still, it can be noted that the setting undergoes a development. In the beginning, many details are added, for instance about her old family house, summer camp, high school and college experiences. But with the outbreak of her illness, such details appear to lose their importance. Interestingly, their importance seems to return with her recovery, as she describes how she decorated her apartment after her last hospitalisation. *"The apartment I live in today is a beautiful place, filled with furniture I picked out by myself, (...)" (Schiller, 1996, p. 199).* This movement from an external focus to an internal focus, back to external focus is reflective of Lori's development and that of her illness, as it first pulls her away from the external world, until it eventually loses its grip on her.

2.3.5 Purpose. Lori's purpose evolves throughout the story. At first, she feels driven to live up to her parents' expectations and to make them proud. However, when her illness breaks out, her purpose shifts. Lori's purpose revolves around the theme of finding one's identity. Her symptoms interfere with her relationships, goals, and self-perception. She wants her old self back, which comes with the rejection and denial of her illness, presenting a central conflict of the story. Her purpose can be seen as a journey toward disease management, self-discovery,

and self-acceptance. Ultimately, she wants to find a new identity, independent of external expectations and beyond the confines of her illness.

2.3.6 Breach. Lori's life seems to be going in the perfect direction, a direction of success that her parents, and ultimately, she herself, had envisioned for her. A social butterfly with straight A's, going off to college with high hopes and dreams. But, with the sudden outbreak of her illness, there is an undeniable crack in that perfect image. And it takes years for Lori to accept the reality of her illness as the new course of direction for her life. For years, she denies even the possibility that she might actually be sick. The breach presents this conflict between her old, successful life with all its high standards and expectations and the reality of her illness.

2.4 Conclusion

The most important storyline in Lori's life revolves around how she identifies with her illness. Her relationship to schizophrenia undergoes major transformations over the course of her life. While at the beginning, she vehemently resists her illness and any treatment approaches, after a long time of sickness and multiple suicide attempts, she slowly begins to realise that she is actually ill. With this insight, she is able to accept and work with the treatment. Then, when she is recovering, she finds herself attached to her illness and everything that is connected to it. She finally embraces a newfound state of health. Thus, her identity undergoes major shifts and loneliness plays an important part at multiple instances in this journey.

When she is introduced to Clozapine, her last and finally successful medication, she describes how she recovers her ability to feel connected to others. Importantly, she describes it as something she had not even realised, she had lost over time. This only underlines the severity of the effect of the illness. And yet, when she slowly regains this ability, she says that she actually actively sought the voices again, missed them even. Like many other psychotic persons, Lori never experiences anything other than negative, aggressive, or depressing auditory hallucinations. So why does she feel the need to reconnect to them after they had been buried by the clozapine? She describes that "without them, I felt lonely". The illness robbed Lori of friends, of a potential boyfriend and a child, of the kind of "normal" life that she imagined herself to have. It cut her off from everything she thought she was going to get and isolated her from those she loved. And at the same time, when the illness recedes, it leaves a hole, an emptiness: "I should have been happy. Instead, I felt like there was a neon vacancy sign flashing. My head felt so empty.". It seems like Lori's loneliness is not only dependent on whether or not she is socially connected. It also has to do with how she relates to herself and

her mind. When something is lost that has been with her many years, even something negative, there is a sense of loss, sadness, and emptiness. A loneliness that perhaps symbolises a loss of self. With the recession of the voices comes what we might call an identity crisis. All people, who go through a recovery process, must also go through a shift in identity. Especially if the illness had significantly altered the life of the person, as it had in Lori's case. The illness had taken away her opportunities, but it had also put her into an environment where she was protected, in some sense. The pressures that were on Lori, like academic achievements, upholding a social status and fulfilling expectations, were removed. Of course, they were replaced by other types of pressures, to the point of her not wanting to continue living multiple times in her life. Nonetheless, having to suddenly be reintroduced into a life of her own, an independent life in which people expect her to go to work, do chores, have a social network and overall be organised and healthy. That can be a tough transition. As Lori had been accustomed to hospital life and her main mission being her recovery, when she finally makes the finish line, when she finally recovers, she feels left alone. The safety of the hospital, the kindness and attention of the mental health care staff leave her. It is then no surprise, that she feels alone in that journey. In this way, it also makes sense that Lori for a long time has trouble accepting the fact she is mentally ill. Confronting that fact separates her from the people she loves and the kind of life she wants to live.

3. Narrative analysis of "A Road Back from Schizophrenia" by Arnhild Lauveng

3.1 Overall Impression

"A Road Back from Schizophrenia" is a deeply personal account of what schizophrenia and psychosis can do with a person's life. What stands out from this particular memoir is Lauveng's ability to describe in rich detail the symptoms of psychosis and how they are connected to and even caused by her life. This story contextualises the experience of schizophrenia in a very unique and empowering way, as she describes herself not as a victim to an illness at all, but as a person dealing with life in an uncommon way, showcasing a full recovery from a condition that is rarely completely overcome. It is a memoir that transcribes hope and inspires a deep questioning of the mental health care system, as Lauveng frequently criticises how she had been treated. In this way it is a passionate account, not a cold observation or half-hearted telling of a tragic story. Instead, it is energetic and poignant in its message, and not at all tragic but encouraging. It reads like a letter to anyone struggling with life and makes her experience, despite its particularity, deeply relatable.

3.2 Summary

"A Road Back from Schizophrenia" is an autobiography by Arnhild Lauveng, a Norwegian woman who is diagnosed with schizophrenia in her late teens. She begins hearing voices and experiencing hallucinations in high-school. Quickly, the symptoms take over her life and she is eventually hospitalised. She goes on to spend many years going from hospital to hospital, in large part separated from her family and friends. She engages in self-harm and attempts suicide several times over the years. Furthermore, she feels lonely and separated from her friends and unable to relate to them due to her hospitalisations. Despite the difficulties she faces, Arnhild is able to make progress in her recovery. She writes about the importance of finding meaning and purpose in life. A big motivation for her is that she one day wants to become a psychologist, but this vision meets a lot of resistance from the healthcare workers around her, many of whom assure her that she will never recover from her illness. She does not accept this prediction and stresses the importance of treating mentally ill people as persons, not as their illnesses. After many years of struggling, she enrols in a psychology program and fulfils her dream of becoming a psychologist. She eventually recovers from schizophrenia, without relying on medication.

3.3 Storyline Analysis: "In any case, she believed in me, (...) we had a plan that actually propelled me toward my goal. Where I had always wanted to go. And it made a world of difference."

3.3.1 Agent. The story is told from the perspective of Arnhild, a young Norwegian woman who developed schizophrenia in her teenage years. As a child, Arnhild describes herself as a *"nice, quiet, good girl that kept to herself and daydreamed a lot and didn't have many friends" (Lauveng, 2012, p. 16).* With her illness, she goes through many developments. First, her identity starts to crumble away, as a young teenager, she slowly becomes *"insecure about whether I really existed, or if I was only a character in a book." (Lauveng, 2012, p. 17).*

3.3.2 Acts and Events. An important point in the outbreak of her illness is the emergence of "the captain" during her early teenage years. A both auditory and visual hallucination which she describes as a manifestation of the high expectations she holds on herself. The "Captain" constantly criticises her and deprives her of food. She becomes psychotic to the point that she is eventually hospitalised. From then on, Arnhild lives in different hospitals for years, most often in closed facilities, as she heavily self-injures.

During many phases, Arnhild is not often allowed home. One time she is allowed to visit her mother, who, despite the hospital's warnings because of Arnhild's destructive behaviour, serves

her porcelain instead of plastic cups. *"I will never forget it. After months and years with expectations of madness and diagnosis and descriptions, they gave me a few May hours at home where I drank tea and trust from leaf-thin porcelain." (Lauveng, 2012, p. 74).*

After a while in therapy, while she is not hospitalised, Arnhild commits several suicide attempts. She is admitted to a closed ward, where a doctor apologizes to her for using violence to admit her, rather than simply talking to her. She has a sliver of hope that she might get better. One important event during her hospitalisation is when Arnhild argues against a doctor's notion that she would forever be sick. *"I said that I would absolutely not learn to live with my symptoms (...) I was told (...) I could never be healthy, and since I insisted upon this goal, I was merely sabotaging the process of learning to live with the symptoms. (...) Luckily, I didn't listen to her. If I had, I would have never gotten healthy, and I would never have the life I live today" (Lauveng, 2012, p. 77).* Arnhild developed an aspiration to become a psychologist herself, which is a vision that gives her hope. Nearly none of the mental health care workers take her aspirations seriously, until she gets a caseworker who *"believed in me, and that day we wrote a plan with a university degree as the goal." (Lauveng, 2012, p. 147).* She starts classes to obtain her high school diploma, first from within the institution, then in regular classes. When things get too demanding, she falls back into psychosis, but then she and her caseworker make new plans and try again. Eventually, she manages to re-enter into her life step by step and even graduates from college, fulfilling her dream of becoming a psychologist.

3.3.3 Means and helpers. Therapy, especially in the period when Arnhild re-enters the world of education and struggles with the sudden demands put on her, significantly helps her *"understand my symptoms and to mature more, so that the images and emotions began to have words and stopped being unmanageable images only. (...) understand the world and my role in it" (Lauveng, 2012, p. 152).* Furthermore, to have people, especially her caseworker, supporting her and her dreams was very relevant for her *"a reason why it worked was simply that therapy became a parallel process to life; I had a life now and something to work on, I was motivated, and I had someone who helped me work on my life with me." (Lauveng, 2012, p. 151).* A crucial turning point in the story is when she is assigned a new caseworker who finally believes in her "*In any case, she believed in me, and that day we wrote a plan with a university degree as the goal. Completely insane. But still, we now had a new plan, and for the first time since I got sick, and that was many years before this, we had a plan that actually propelled me toward my goal. Where I had always wanted to go. And it made a world of difference.*" *(Lauveng, 2012, p. 233).*

3.3.4 Setting and scene. There are fundamentally two types of settings in Arnhild's story: Inside and outside the hospital. Arnhild emphasises at several instances within the story how dull, boring and colorless the hospitals are, where she resides most of the time during the story. Sometimes she has to stay inside for months at a time, adding to the sense of captivity and hopelessness. The dullness of the hospital environment seems to also symbolically connect to how she feels herself during many phases during her illness. She describes her state of being as *"just gray" (Lauveng, 2012, p. 17)*, as she struggles with feeling positive feelings or the dulling, tiring effects of medications and even keeping her sense of identity intact. Thus, there is an element of this colourlessness both in an internal and external dimension, which draws the reader into Arnhild's experience. In contrast stands the aliveness and colourfulness of the outside world, of nature and sunlight, whenever she gets the opportunity to enjoy these.

3.3.5 Purpose. Arnhild's purpose is to become healthy, free of symptoms, and to fulfil her career dream of going to college and becoming a psychologist. Furthermore, she craves human connection, many times even self-injuring in order to receive it "*...when the loneliness grew bigger, and the voices were roaring, and I really needed someone to talk to, I would cut myself. The nurses couldn't ignore me then..." (Lauveng, 2012, p. 50).*

3.3.6 Breach. The main conflict in the story is that Arnhild wants to be seen and respected as a human being capable of defining her own life, yet she is reduced to her illness, her symptoms and her diagnosis. Her desire to be seen is showcased in her appreciation of her mother when she serves her porcelain cups, or in her gratitude for a doctor who apologized for misbehaving after one of her suicide attempts, *"He apologized for using force instead of talking to me and instead of trying other alternatives first. That was the first and only time a doctor has ever apologized to me, and I thought it was amazing." (Lauveng, 2012, p. 94).* She expresses how the wish to become healthy was met with a lot of resistance from healthcare workers, who insisted that she give in to her illness. This is the main conflict of the story. Arnhild wishes to recover fully and to fulfil her career dream. It is not only her symptoms that conflict with her purpose, but also the health care system she is living in, mostly including the expectations of the doctors and nurses around her. The expectations connected to her diagnosis seem to put a lens on everyone she meets, especially health care workers, a matter that is extremely isolating for her. *"It is very lonely, and quite scary, to lose the content of your words, and they, in turn, become a symptom. I still remember the enormous feeling of helplessness and fear when I realized that there was no longer any neutral area, and that I had to expect that no matter what I said it would be misinterpreted because of my diagnosis." (Lauveng, 2012, p. 81).*

3.4 Conclusion

Arndhild's hospitalisations are connected to her experience of loneliness. On the one hand, the symptoms she experiences, which are the reason she is hospitalised several times in the first place, are isolating her from others and the world outside of herself. On the other hand, the hospital environment physically isolates her from the people close to her, like her family or high school friends. On top of physical isolation, because Arnhild spends several years in hospitals, she eventually loses all ground to relate to friends from her past, which erodes her social circle. But why is the hospital environment so isolating? There are nurses 24/7 around her, taking care of her. There are doctors giving her constant attention. Ultimately, it appears, Arnhild's journey is about finding a human connection with those around her, despite her symptoms, despite her illness. And yet, she is often treated with distance by the staff, her wishes and aspirations are ridiculed. What stands in the way between Arnhild and everyone else, is largely the stigma that is projected onto her. When she expresses her wish to become a psychologist one day, the people around her mostly do not take her seriously. She is expected to be impaired by her illness long term, dependent on medication for as long as she lives. Whatever is expected of a person with schizophrenia, has merged with what people expect from her. How can she feel connected to those around her when she is not seen as herself, but merely as her illness? Arnhild's story highlights how identity and the stigma that is attached to it, plays into social relationships and loneliness.

4. Comparative Analysis

There are similarities and differences between the three different storylines presented in these three cases. All three agents experienced loneliness, but it was not a purely negative experience for all of them. Stigmatisation and how it affected the agent's identity was a central aspect connected to the experience and meaning making of loneliness, in all three stories. However, not always in the same way.

Internalised stigma was especially relevant for both Cordt and Lori. Cordt heavily resists facing the fact that he is experiencing symptoms of schizophrenia when he is in the prodromal stage. When his illness breaks out, he is riddled with feelings of embarrassment. Throughout his life, he avoids asking for help too often, he often isolates, and he experiences shame around his illness. All of this is a sign of internalised stigma (Burke et al., 2016). In a very similar way, Lori resists the diagnosis of schizophrenia, or any sickness at all, even after several psychotic episodes and hospitalisations. Stigmatisation of people with psychosis may

have played a big factor in why Lori was unable to accept her illness for so long. Accepting it not only means accepting a path to improvement and access to treatment, but also accepting the negative beliefs one has internalised, as well as facing external forces of stigmatisation. For Lori, internalised stigma also played a role in her denial of the illness itself for many years, as her denial "protected" her from feeling different and therefore disconnected from everyone else. In contrast, Arnhild is struggling especially with stigmatisation by other people. The way the healthcare system projects what is expected of schizophrenic patients onto her, limits her ability for recovery, and plunges her into feelings of loneliness. In contrast to Cordt and Lori, it is in a sense the rejection of the illness or at least the rejection of the stigmatising and limiting notions connected to the illness that help Arnhild in her recovery, rather than assimilating it and its limits into her identity.

Another important lens through which loneliness becomes meaningful for all three agents is the role of identity. In all three analysed cases, the restoration of identity seems to be an important aspect to the recovery process in psychotic disorders. Both Lori and Cordt struggle heavily with identifying themselves with their illness and integrating it into their identity, especially because they feel it separates them from other people and their old life in general. Both of them had to let go of their prior sense of identity, which did not include psychotic symptoms, to let it be deconstructed. Lori's moment of deconstruction is in a period of aloneness and extreme loneliness, in which she is finally able to let go of the notion that she is healthy. This, in turn, leads to the possibility of restoring an identity, which is the case for both Lori and Cordt. Arnhild too experiences a loss of identity, and at one point in the course of her illness even uses the third person to describe herself ("She was walking to school", instead of "I was walking to school").

All three cases go through a restoration of self. Arnhild returns in a sense to her prior sense of self (as the title suggests: A road **back** from schizophrenia) and into a state which she describes as free from the illness completely. Lori and Cordt more so assimilate the illness into a functional version of themselves. Lori's turning point in accepting her illness and igniting her recovery occurs during her time at a halfway house, where she reflects on her life in solitude and slowly accepts her illness as a new part of her identity.

Discussion

The aim of this study was to gain a nuanced understanding of how people with psychosis experience their loneliness. To do this, three autobiographical books were analysed using narrative analysis. The research question was: "How do people with psychosis experience their loneliness?". There are several findings that explain different aspects of the experience of loneliness. First, loneliness was present in all cases and was often experienced as a negative emotional experience. However, it also showed to be beneficial for the recovery process in some cases. Second, stigmatisation played an important role in the construction of loneliness. Especially internal stigma and stigma related shame were connected to loneliness. Third, identity formation and identity loss appeared to play a significant role in the recovery process. For instance, assimilation of the illness into the identity of two cases allowed openness to treatment and reduction of emotional resistance.

Loneliness as negative and positive aspect

Loneliness was present as a negative emotional experience in all three storylines, perhaps because it is such a universal human experience (Cacioppo et al., 2014). All cases experienced some degree of social isolation, be it through hospitalisation or withdrawal of self or others. Furthermore, all cases reported feelings of loneliness. Therefore, this study confirms the findings of previous research that loneliness is an essential component of the difficulties faced by people with psychosis (Morgan et al., 2017). However, loneliness has presented itself as a much more nuanced experience than it may appear. While it can be distinguished between emotional and social loneliness (Weiss, 1973), or loneliness as a simple negative reaction to unmet social needs (Peplau & Perlman, 1982), there appears to be a plethora of research settling on its meaning as a negative experience in the context of mental illness (Badcock et al., 2020; Huckle et al., 2021; Morgan et al., 2017). In contrast, this study found positive effects of social withdrawal in one of the analysed storylines. The period of aloneness helped in a process of reflection and acceptance of the state of illness, supporting the process of recovery and treatment. This finding corroborates the findings of a review by Seeman (2017), who considered what solitude means for people suffering from schizophrenia. The review points out that while solitude, or self-isolation, is sometimes a sign of social anxiety, it often also has a positive meaning for many individuals. One benefit for instance is the ability to retreat and recover from overstimulation. Another benefit is that the sense of self and independence of the individuals could be recovered away from social pressures. The findings of this review by Seeman (2017) are also present in this study. Frequent withdrawal from others as a means of

processing and the negative feelings of loneliness itself were essential in the recovery process in the analysed cases. As such, it follows that experiences of being alone are possibly beneficial to individuals suffering from psychosis. This may be important in considering how aloneness should be interpreted in the context of the lives of people with psychosis. Especially since, it appears, withdrawing and feelings of loneliness are often interpreted as bad signs in the course of illness (Badcock et al., 2020; Huckle et al., 2021; Morgan et al., 2017).

The Role of Stigma in Loneliness

The findings of this study also highlight the role of stigma in experiences of loneliness. External stigma, especially the stigmatizing attitudes exhibited by mental health care workers, played an important role in contributing to feelings of loneliness in one of the analysed cases. This finding is corroborated by a meta-analytic review by Michalska Da Rocha et al., (2018), which suggests how psychotic symptoms invoke stigma in others, which is correlated with feelings of exclusion. A similar dynamic as the one present in the analysed case is also present in another review of qualitative studies by Mestdagh and Hansen (2014). Patients in the reviewed studies report that they are often overprotected and not taken seriously by people around them, including mental health care workers. They also report the wish to be seen as a person, not as "mentally ill" and incapable of making their own decisions. Thus, this study points to how stigmatising attitudes of this nature, notably in the form of reducing patients to their diagnosis and projecting limitations onto them, can be connected to loneliness that individuals who experience psychosis. At the same time, in two of the analysed cases, external stigma was very limited if not absent. Yet, feelings of shame and behaviour that could be interpreted as reactions to stigma were present in those cases, signifying the presenece of internal stigma, rather than external stigma.

Internal stigma in this context refers to internalising and applying to oneself the negative stereotypes about one's own mental illness (Brohan et al., 2010). Internalised stigma led two cases to both feel embarrassment and shame regarding their illness. The findings of this study are present in other research too. For instance, a qualitative analysis by Burke et al. (2016) stresses how internalised stigma can negatively impact individuals with psychosis, leading to "A sense of abnormality and difference" for example. This describes an essential aspect of self-isolation, the feeling of being different from others, of not belonging. Moreover, they found a connection of stigma with feelings of shame and embarrassment. Other research also suggests that people suffering from psychosis may isolate themselves due to internalised stigma and a fear of rejection (Corrigan et al., 2009). This present study corroborates the

findings of other studies, all cases were faced with and struggled with the effects of stigma. Thus, stigma, especially internal stigma, could be conceptualised as a driving force in creating a sense of isolation, of separation between those deemed healthy and those unfortunate enough to be categorised as mentally ill.

Identity restoration

More so than merely internalising stigma, this study suggests that the experience of psychosis can have profound effects on the identity of a person. Two of the analysed cases managed only through intense struggle to accept their illness and to assimilate into their identity structure. A struggle that led to feelings of loneliness and even identity loss. This finding is also reflected in a review of qualitative studies by Ben-David & Kealy (2020). They found an overarching theme of identity loss due to the outbreak of psychosis. Especially young people frequently reported how their condition had deconstructed the continuity of their self-concept and the emotional struggles that came with it. An important theme found by Ben-David & Kealy (2020) was "restoration of identity", which in a sense describes the positive reconstruction process after the illness first led to a deconstruction of identity. Through the challenges posed by their condition, individuals may eventually restore their sense of identity, even though it is changed over the course of their illness. These findings suggest the importance of identity change during the course of illness and point to how the deconstruction process can be extremely uncomfortable and lonely, but also necessary.

Implications, Strenghts and Limitations

This study seems to suggest that more nuances should be taken into consideration when it comes to experience of loneliness in people with psychosis. Much research seems to focus on the negative aspects of loneliness, and many interventions are largely designed with the intention of eradicating it (Lim et al., 2020). However, qualitative accounts like this study point to the complexity of a concept like loneliness. Future quantitative studies may research how the more beneficial aspects of loneliness, for instance solitude, reflection and identity restoration, could be developed in individuals with psychosis. And importantly, further specify in what contexts loneliness, or rather solitude, is beneficial and when it should rather be avoided. A more nuanced and multidimensional collection of interventions could be designed, which take the intricacy of the issue into account. For instance, interventions could aim to help people with psychosis make sense of their experiences of loneliness and draw on the beneficial aspects of solitude. Furthermore, mental health facilities and services could facilitate identity

formation in patients who are in a time of reflection, all the while both supporting solitude and social engagement simultaneously. How and to what extent such procedures should be used, could be the subject of further research.

Furthermore, this study points to how stigmatisation is highly relevant in the construction of loneliness experience. Especially, internal stigma seemed to be present and relevant in two cases. As such, further qualitative research on how internal stigma and shame are experienced by people with psychosis might further clarify its role in the illness. Additionally, interventions designed to minimise disruptive loneliness should perhaps consider the reduction of shame and internal stigmatisation as a core intervention-component. Gumley et al. (2010) discuss possible uses of compassion focused therapy in the context of psychosis recovery and highlight how self-compassionate soothing can be a vital for individuals who struggle with shame and self-criticism. Compassion based approaches may be essential in providing the necessary support for individuals suffering from internalised stigma. Aside from internal stigma, external stigma can, based on one of the cases, also play a crucial role in the illness and recovery process. External stigma is much more a collective issue than it is an individual one. Many interventions are targeting the social skills of individuals with psychosis to reduce loneliness, indicating an individual lens for problem-solving. For instance, intervention design is encouraged to help individuals deal with negative thinking patterns or utilise positive emotions to strengthen relationships (Lim & Gleeson, 2014). In some cases, it may be reasonable to use a societal perspective and view the issue of loneliness in terms of the environment that people with psychosis are embedded into. Future researchers may take such a systemic view into account when arranging research studies or designing interventions.

The suggested implications of this study should be considered in context of its strengths and weaknesses. This study emphasises the use of qualitative research similarly to previous qualitative studies that have revealed important themes in the lives of people with psychosis (Ludwig et al., 2022; McCarthy-Jones et al., 2013). The benefit of qualitative research is that it can uncover in-depth and information rich accounts of individuals, revealing perspectives and details that can be used to understand the subject in question (van de Bovenkamp et al., 2020). Interview studies, such as the one conducted by Ludwig et al. (2022), provide extensive information on individuals, which allow a meticulous type of analysis that quantitative methodologies do not offer. This present study also used a qualitative framework, but did not use interviews and did not uncover themes as such. Instead, autobiographies were analysed using narrative analysis based on the framework of Murray and Sools (2014). Compared to interviews, autobiographies are usually much longer and therefore include much more in-depth

and extensive information, which are essential components of why qualitative research is beneficial. Additionally, the information in autobiographies spans over a long time-frame and therefore illustrates the development of the protagonist across their life. A paper by Power et al. (2012) highlights how autobiographical accounts of patients present a valuable resource in shaping health care. They emphasise how writing can express the magnitude of the human experience in a comprehensive manner, revealing the thinking, feeling and humanity of patients in question. By choosing autobiographical data, this study makes use of its inherent, aforementioned advantages. Additionally, the analysis method that was used, narrative analysis, is particularly suited for autobiographical data and allows for examining how the writers attributed meaning to their experiences (Sharp et al., 2019), which is an essential component of the research question in this study. Future studies may consider using autobiographical data as well, in order to further clarify how people with psychosis experience different aspects of their lives. An additional benefit of using autobiographies, is that they are an easily accessible data source, most often publicly available (Power et al., 2012). This allows future research to effortlessly continue research in this direction, to corroborate or disconfirm the findings of this or other, similar studies.

Aside from acknowledging the implications of this study, its limitations should be considered as well. Inherent to the design choices of this study, there is a bias in the data collection. For instance, only people who were able to write an autobiography on their life were included in the analysis. Writing an autobiography already assumes a certain degree of functionality. Therefore, the experiences of people with psychosis who would not have been able to do this, for instance due to their illness taking a more severe course, were completely omitted. Furthermore, narrative analysis is a very extensive analysis method with various steps. Hence, due to time constraints, this study only analysed three autobiographical books. Consequently, future research is needed to substantiate the insights gained in this study. Naturally, since this is a qualitative study, the goal was not extensive generalisability. Instead, this study aimed for transferability. As such, the conclusions drawn from this study can hopefully be transferred to other settings and contexts, even though they should not be generalised to the larger population of people with psychosis. It should be mentioned that even though only three books were examined, there were considerable differences between cases. There were also many similarities, but including more books in future analysis may reveal diverging information that could further enhance our understanding of people with psychosis. Further considerations about the implications, strengths weaknesses of this study should be

made concerning the unique methodological approach that was followed and the specific design choices that were made along the way.

Methodological Reflection

This study is somewhat pioneering in its use of narrative analysis with autobiographical books, as few studies in the past have used this approach. Especially when it comes to analysing entire books, not just text sections. Due to the fact that there is little use of this particular research method with this particular medium, the specific way of using the methodology was somewhat ambiguous. Because the information from each book was so extensive, a variety of potentially relevant and interesting themes and topics were present in the data. It would have been possible to "pick apart" the story by analysing its different elements separately and working out separate storylines and distinct themes. Instead of using this approach, however, this study focused on each story as a whole. None of the books were separated into different storylines, and finding many separate themes was not emphasised. The downside to this approach is that potentially important themes and sub-storylines are not addressed. However, it also reduces the risk of losing the rationale and overarching meaning of the story as a whole, which was important for this research project. The emphasis of the research question was not on finding a multitude of different factors that were related to experiences of loneliness. More so, the purpose of this study was concerned with understanding the underlying perspective of individuals with psychosis on their loneliness. In order to gain an understanding that is based on a larger life context, each story was examined as a whole. This study had to find a balance between dissecting and zooming out to perceive the narrative as a unified entity. In the end, this study found what may be called themes, but they are themes that emerged in the context of each autobiography as a whole.

Because this methodology and approach is novel, future research could go in any number of directions in applying this research method. Some studies may divide the stories more and uncover separate layers and aspects, while others focus more so on the overarching logic of the narrative. It is important to be aware that there may be stark differences in how narrative analysis can be structured and executed. Future researchers should consider the different available ways of using this methodology and make decisions based on their research aims and research questions. Distinguishing between different approaches also helps in drawing fitting conclusions and insights and in properly comparing studies. In fact, it may be important in the future to clarify the nuances and possibilities of narrative analysis with data like autobiographies in order to ensure systematics and comparability. With more research

conducted with this research method and similar types of data, systematic differences in the various approaches could better be distinguished and better conceptualised, eventually leading to a less ambiguous use of the method.

Conclusion

In conclusion, this study aimed to get a more nuanced understanding of loneliness from the perspective of people with psychosis. Through narrative analysis of autobiographical books, important aspects of the experiences of loneliness were revealed. The study underscores the important role that stigma, both internal and external, plays in shaping the experience of loneliness. While loneliness is often viewed negatively, this study revealed potential positive aspects of loneliness or solitude and how they can be a part of the recovery process. Loneliness from a positive point of view may help by providing space for reflection, self-acceptance, and identity change and restoration. The findings challenge the notion that loneliness is a solely negative emotional experience. This study aims to inspire future research to further consider the role of loneliness in the recovery process of psychosis and suggests future interventions to consider both beneficial and detrimental aspects of loneliness in the context of psychosis. Finally, this study shows a possible application of narrative analysis and encourages researchers to further use and refine this research method with extensive units of qualitative data like autobiographic books.

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