# A Qualitative Study on Social Alienation Experiences in Young and Middle-aged Adults with Schizophrenia in Remission: Postprint

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## Abstract

Background Social alienation refers to an individual's inability to interact effectively with those around them or to have their social interaction needs met, leading to self-alienation or social isolation. Patients with mental illness are affected by the stigmatization of mental illness, and patients with schizophrenia often perceive relatively severe social discrimination throughout their lifespan. Currently, research on social alienation in young and middle-aged patients with schizophrenia in remission is limited. Objective To describe the experiences of social alienation in young and middle-aged patients with schizophrenia in remission, aiming to provide reference for developing supportive intervention programs to alleviate social alienation experiences in this population. Methods Using purposive sampling, young and middle-aged patients with schizophrenia in remission aged 18-59 who had been hospitalized at the Second Affiliated Hospital of Xinxiang Medical College and were willing to continue follow-up after discharge were selected as study subjects. From May to December 2022, face-to-face semi-structured in-depth interviews were conducted with the respondents, and themes were summarized and extracted using content analysis. Results A total of 18 young and middle-aged patients with schizophrenia in remission were included. Through analysis of the interview data, three themes and eight sub-themes were extracted: manifestations of social alienation in young and middle-aged patients with schizophrenia in remission (including two sub-themes: negative emotional experiences and withdrawal between expectations and behaviors); subjective reasons for social alienation in young and middle-aged patients with schizophrenia in remission (including two sub-themes: self-alienation and self-stigma); and objective reasons for social alienation in young and middle-aged patients with schizophrenia in remission (including four sub-themes: social discrimination and passive alienation, effects of adverse drug reactions, increased life and care burden caused by mental illness, and lack of social support). Conclusion Young and middle-aged patients with schizophrenia in remission experience social alienation due to impaired physical health, poor psychological status, and insufficient social support. Medical staff should strengthen symptom management and psychological counseling for this population, while the government and all sectors of society should actively guide positive perceptions of mental illness and provide certain social support; simultaneously, family internal support should be enhanced to help them return to and adapt to society.

## Full Text

# A Qualitative Study on the Social Isolation Experience of Young and Middle-aged Patients with Schizophrenia in Remission

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### Abstract

**Background:** Social isolation refers to the inability of individuals to interact effectively with their surroundings or have their willingness to engage in social interaction satisfied, resulting in self-isolation or social withdrawal, often accompanied by varying degrees of loneliness and meaninglessness. Patients with mental illness are affected by the stigmatization of mental illness, and individuals with schizophrenia often experience severe social discrimination throughout their entire lives. Limited studies have examined social isolation in young and middle-aged patients with schizophrenia in remission.

**Objective:** To describe the social isolation experience of young and middle-aged patients with schizophrenia in remission, aiming to provide reference for developing supportive intervention plans to alleviate social isolation in this population.

**Methods:** A purposive sampling method was used to select young and middle-aged schizophrenia patients aged 18-59 who had been hospitalized at the Second

Affiliated Hospital of Xinxiang Medical University and were willing to continue follow-up after discharge. From May to December 2022, semi-structured in-depth interviews were conducted face-to-face with participants, and themes were extracted using content analysis.

**Results:** A total of 18 young and middle-aged patients with schizophrenia in remission were included. Analysis of interview data yielded three main themes and eight sub-themes: manifestations of social isolation in young and middle-aged patients with schizophrenia in remission (containing two sub-themes: negative emotional experience and withdrawal between expectation and behavior); subjective reasons for social isolation (containing two sub-themes: self-alienation and self-stigma); and objective reasons for social isolation (containing four sub-themes: social discrimination and passive alienation, effects of adverse drug reactions, increased burden of living and care caused by mental illness, and lack of social support).

**Conclusion:** Young and middle-aged patients with schizophrenia in remission experience social isolation due to impaired physical health, poor psychological status, and insufficient social support. Healthcare professionals should strengthen symptom management and psychological counseling for this population. The government and society should actively guide positive perceptions of mental illness and provide social support, while strengthening family support to help patients reintegrate and adapt to society.

**Keywords:** Schizophrenia; Social isolation; Remission period; Young and middle-aged people; Semi-structured interviews; Qualitative research

## Introduction

Social isolation refers to the inability of individuals to interact effectively with those around them or to have their desire for social engagement satisfied, leading to self-alienation or social withdrawal, often accompanied by varying degrees of loneliness and meaninglessness [?]. Patients with schizophrenia frequently perceive severe social discrimination throughout their lives [?]. For young and middle-aged patients with schizophrenia, integrating into society is particularly challenging, as the illness creates substantial pressure related to returning to work, social integration, and family burden. These patients require long-term antipsychotic medication, yet adverse drug reactions can reduce work capacity, heighten perceived stigma and discrimination, and impair social interaction and integration [?].

Domestic research on social isolation has primarily focused on older adults [?], adolescents [?], and cancer patients [?], with limited in-depth investigation into social isolation among patients with mental illness, particularly young and middle-aged individuals. Current domestic scholarship on social isolation in psychiatric patients has predominantly employed quantitative methods [?], focusing on status surveys and influencing factor analysis. While a few foreign scholars have conducted relevant interviews, these have centered on "social identity" and "stigma" without deeply exploring the social isolation experiences of young and middle-aged schizophrenia patients in remission. Therefore, this study conducted in-depth interviews with young and middle-aged patients with schizophrenia in remission to explore their authentic experiences of social isolation, providing a reference basis for developing nursing support programs and facilitating their return to society.

## Methods

### Study Participants

Using purposive sampling, participants were selected based on maximum variation principles considering gender, age, education level, and disease duration. Young and middle-aged patients with schizophrenia in remission who attended follow-up appointments at the Second Affiliated Hospital of Xinxiang Medical University between May and December 2022 were recruited.

**Inclusion criteria:** (1) Diagnosis of schizophrenia according to ICD-10 criteria [?], with disease status confirmed as remission by two attending psychiatrists or higher-level specialists [?]; (2) Age 18-59 years; (3) Previous hospitalization at our institution with willingness to continue follow-up after discharge; (4) Informed consent obtained from both patients and guardians with signed written consent forms.

**Exclusion criteria:** (1) Severe physical illnesses such as epilepsy, cerebral infarction, or heart disease; (2) Mental retardation; (3) Other conditions unsuitable for participation.

Sample size was determined by data saturation. When no new information emerged after 18 interviews, data collection was concluded. All 18 participants voluntarily participated in the study, which was approved by the Ethics Committee of the Second Affiliated Hospital of Xinxiang Medical University [XYEFYLL-(Research)-2021-01-02]. The sample included equal numbers of men and women, with disease duration ranging from 1-10 years. Basic participant information is presented in Table 1 .

### Development of Interview Guide

Based on social-ecological systems theory [?], a preliminary interview guide was developed through consultation with psychiatric and psychology experts and pilot interviews with three young and middle-aged patients with schizophrenia in remission. The final interview guide was formulated incorporating expert feedback and pilot results. The interview questions included:

1. Where do you live after discharge? What do you usually do?
2. How do you feel about the attitudes of people around you when you return home after discharge?

3. Do you choose to work after discharge? How do you view employment?
4. What difficulties have you encountered during your recovery process?
5. What factors do you think increase your distance from society?
6. When your condition is stable, are you willing to participate in group activities such as gatherings or travel?
7. What difficulties have you encountered when interacting with others in daily life? What experiences have you had seeking emotional support from others?
8. When your condition is stable and you return to work, how do you handle others' unusual attitudes toward you?

### Data Collection

Prior to interviews, informed consent was obtained and signed. Interview record forms included demographic information such as gender, age, current living status, and residence location. Interviews were conducted in quiet, private rooms to ensure confidentiality. Participants were informed of the study's purpose and content, assured that information would be used solely for research purposes with privacy protected, and guaranteed that all data would be treated equally regardless of scientific utility. Real names were replaced with identification numbers.

During interviews, researchers first introduced themselves and asked simple rapport-building questions (e.g., "Did you schedule your follow-up with your doctor? What medications are you taking? How have you been eating and sleeping? Are you taking medication as prescribed?"). The formal interview guide was then implemented with flexible adjustments based on participants' responses to ensure smooth progression. All interviews were audio-recorded, lasting approximately 45 minutes. Researchers carefully observed and documented participants' facial expressions and body language. At the conclusion of each interview, clarifying questions were asked to ensure accuracy of information.

### Quality Control

To minimize sampling bias, diversity in participant selection was ensured. Open-ended questions allowed participants to express genuine feelings. Immediately following interviews, textual information and paper documents were backed up, and recordings were transcribed promptly. Any unclear aspects were verified through telephone follow-up with participants during data organization to ensure authenticity and accuracy.

## Results

Analysis of interview data from 18 participants yielded 528 meaningful semantic segments, from which three main themes emerged: manifestations of social isolation, subjective reasons for social isolation, and objective reasons for social isolation.

### Manifestations of Social Isolation in Young and Middle-aged Patients with Schizophrenia in Remission

**Negative Emotional Experiences** This subtheme encompassed feelings of loneliness, inferiority, helplessness, and masked emotions.

**Loneliness:** Participants often felt internally isolated, rejected, and unaccepted by the outside world after developing mental illness, resulting in profound loneliness. As P2 expressed: "No one truly understands. Only patients themselves know that feeling—the feeling of being rejected by society is truly unbearable and impossible for others to genuinely comprehend. Though they say they understand my situation and feelings, I know that only fellow patients can truly understand the experience of being alienated. This loneliness emerges especially when I'm alone, particularly in cold, isolated environments."

**Inferiority:** Many patients experienced self-deprecation and self-negation during remission when they gained some understanding of their illness, unconsciously avoiding contact and communication with others. P3 stated: "I often feel inferior, like I'm less than others, and don't want to go out and see people."

**Helplessness:** Some participants described feeling intense anxiety and fear due to the uncontrollable nature of their illness (sudden onset, symptom recurrence, and the reality of lifelong medication), which impaired their ability to concentrate and engage in normal social interactions. P9 shared: "I worry about others looking at me differently. I hope no one knows about my illness, yet I know this is impossible to hide. The thought of being discovered makes me extremely nervous, so this is a constant concern."

**Masked Emotions:** Most participants intentionally concealed their negative emotions, deliberately presenting an optimistic and positive demeanor during social interactions to maintain relationships. However, underlying feelings of loneliness, helplessness, and depression intensified. P6 noted: "I always smile in public like I'm wearing a mask, but at home I'm often expressionless and don't want to speak." P10 added: "When I'm in busy, crowded places, I feel temporarily calm, but once quiet—especially at night when everything is silent and no one talks to me—I become extremely depressed and can't control my racing thoughts." P14 explained: "So I always numb myself by staying up late watching dramas or online shopping."

**Withdrawal Between Expectation and Behavior** This subtheme included rejecting the benefits of others' help, mismatch between inner expectations and behavior, and psychological defensiveness.

**Rejecting Help:** Most participants believed that even their closest family and friends couldn't truly understand the pain of mental illness, viewing their comfort as meaningless platitudes and actively rejecting assistance. P5 stated: "I have many friends, but few genuinely care about me. I don't want sympathy or pity—it makes me feel like a failure—so there's no point in confiding in them." P6 added: "There's no need to seek help from others; they may not truly want to help."

**Expectation-Behavior Mismatch:** Participants deeply desired to maintain social connections and integrate into society, yet feared social interaction, leading to withdrawal. P8 shared: "Sometimes I want to go out and chat with friends, but I don't know where to go or what to say, so I often stay home alone." P18 expressed: "I really want to step out boldly, but I retreat at the thought of others' judgment."

**Psychological Defensiveness:** Even after recovery, some participants felt different from others and heightened their psychological defenses when approached, fearing discrimination and harm. P11 noted: "Mental illness is special—not like a common cold. I worry that even if I make new friends, they'll eventually distance themselves." P17 added: "I feel many people who offer help nowadays have ulterior motives."

### Subjective Reasons for Social Isolation in Young and Middle-aged Patients with Schizophrenia in Remission

**Self-Alienation** This subtheme encompassed voluntary withdrawal from others, fear of privacy disclosure, and abandonment of long-term goals.

**Voluntary Withdrawal:** Most participants reported consciously choosing to live in a confined environment after recovery, distancing themselves from family, friends, and colleagues. P7 described: "After discharge, I lock myself in my bedroom. Except for eating and using the bathroom, I just lie in bed. I'm not happy at all, but I simply don't want to go out. I want to trap myself in this room, enclosed." P13 shared: "After getting this illness, even when recovered, I'm afraid to go out and meet acquaintances. During that time, relatives and friends kept calling, but I didn't want contact with anyone. Even when I did interact, it was perfunctory."

**Privacy Disclosure Concerns:** Participants expressed intense fear of others discovering their psychiatric history, noting widespread aversion toward mental illness. P14 stated: "I'm terrified of people finding out I was hospitalized in a psychiatric institution. It feels like a shameful stain on my life, yet I'm helpless because I am ill." P15 added: "People scoff at the mention of psychiatric patients. If they knew about my illness, they'd certainly despise me. If my workplace leaders knew about my hospitalization or medication, I fear they might fire me. Even if not, my promotion prospects would be ruined."

**Abandoning Long-term Goals:** Some participants expressed hopelessness about the future, believing their illness had fundamentally changed their life trajectory. Even highly educated patients saw no prospects ahead. P12 lamented:

"With this illness, I feel my life is over. I can't work or have friends. I don't even know how to face the future or dare to hope, because there is no hope." P15 concluded: "With this illness, my entire life will be spent treating it and taking medication—there's simply no hope."

**Self-Stigma** This subtheme included internalized stigma and shame, self-imposed safety zones, devaluation of self-worth, and cognitive-behavioral dissonance.

**Internalized Stigma and Shame:** Some participants felt profound inferiority and guilt, constantly blaming themselves. P6 shared: "I feel inferior and guilty, terrified I might suddenly relapse and harm others."

**Self-imposed Safety Zones:** Many participants reported not going out for extended periods, explaining that society's low acceptance of mental illness meant reducing external contact could prevent harm. They believed staying in their "safe zone" minimized opportunities for discrimination. P5 explained: "When people hear 'schizophrenia,' they think it's madness. Everyone discriminates against those with this illness. I prefer staying in what I consider my safe zone to avoid harm." P9 added: "After reading posts in our [young and middle-aged remission] group for a day or two, I became even more afraid. I didn't want to face reality—just wanted to hide endlessly."

**Devaluation of Self-worth:** After diagnosis, patients experienced inferiority and anxiety about the future, feeling worthless and burdensome to their families, unable to contribute. They perceived themselves as liabilities to both family and society. P15 expressed: "Seeing many fellow patients hospitalized repeatedly with long illness durations and high costs, I feel my existence is a family burden. I can't contribute and instead need care. My family wants to help, believing I can recover and live and work normally. It's painful—I may just be a burden." P13 stated: "Why even look for a partner? This illness means I shouldn't marry—I'm useless."

**Cognitive-Behavioral Dissonance:** Many participants repeatedly questioned interviewers about the curability and remission of mental illness and the need for long-term medication, remaining troubled and concerned about relapse. Despite receiving positive affirmations, they maintained skeptical attitudes. While mental health professionals have recognized this self-cognition issue and intensified educational efforts, cognitive and behavioral dissonance persists. Even with restored insight and some disease understanding, subjective cognition and behavioral biases led individuals to reduce social interaction. P11 noted: "Doctors always say active treatment compliance and medication can effectively control the illness, but it's hard to accept their explanations personally. I tend to follow my inner beliefs and thoughts, then actively withdraw." P5 added: "Although doctors say proper medication can control symptoms and reduce relapse, my online research suggests it's difficult, requiring constant hospitalization and medication with minimal success probability. Doctors keep saying the government will prioritize mental illness assistance in the future, but it feels too distant."

### Objective Reasons for Social Isolation in Young and Middle-aged Patients with Schizophrenia in Remission

**Social Discrimination and Passive Alienation** Throughout interviews, most participants repeatedly mentioned "social discrimination," which deeply troubled them. The general public largely holds rejecting attitudes toward mental illness patients, with discrimination being widespread. Some people experience fear when encountering young and middle-aged patients with schizophrenia in remission, worrying about sudden aggressive behavior and consequently keeping their distance. In essence, "social discrimination" constitutes a major barrier preventing mental illness patients from integrating into society, exacerbating perceived stigma and resulting in passive social withdrawal. P10 explained: "Society doesn't understand mental illness deeply enough, often viewing psychiatric patients as 'madmen' and fearing sudden attacks. So they keep their distance. Even when doctors say I'm recovered and symptoms are controlled, I know they'll still be wary and won't truly let go of their resistance." P8 shared: "In rural areas, people are superstitious, believing mental illness is a strange, incurable punishment from heaven—karma for family wrongdoings. They think I'm a bad person, that mental illness is just mental illness and can't be cured." P2 added: "Family members worry I'll affect my children's development or pass on the illness genetically, believing it will impact their future, friendships, employment, even marriage. Some fear the children will become mentally ill too. My in-laws even demanded divorce, believing having a mentally ill family member would bring shame in the community. They wanted me gone, pretending I don't exist [deliberate alienation]."

**Effects of Adverse Drug Reactions** Long-term regular medication is necessary during treatment, yet antipsychotic drugs have numerous adverse effects that constrain patients and force them to distance themselves from family and friends. P4 noted: "Doctors told me to avoid smoking and drinking during medication to prevent reduced efficacy and relapse. As a man, this means less socializing and greater distance from friends." P3 shared: "This medication causes weight gain—it's ugly. I even drool when speaking, which is embarrassing. Better not go out."

**Increased Burden of Living and Care** The illness intensifies life and work pressures while severely impacting employment prospects. P8 expressed: "I worry about normal life, about finding suitable work. Mental illness means repeated hospitalizations—what job will always be reserved for you? Long-term hospitalization also disconnects you from society. Can you still perform after discharge? No work means no income—how do you afford medication and living expenses? Even if you find work, colleagues will ask about your illness when you take medication. Many psychiatric drugs cause weight gain and drowsiness, affecting normal work. And many good employers—state-owned enterprises, central enterprises, public institutions—we're basically excluded from them."

**Lack of Social Support** This subtheme encompassed desire for listeners and helpers, need for peer support, concerns about post-discharge work and life security, and hope for fair treatment of themselves and their families.

**Desire for Listeners and Peer Support:** Most participants reported craving care from relatives and friends, hoping for support during loneliness and helplessness. P8 shared: "I especially hope for someone—a friend—who can help me, listen to me. They may not actually help with anything, but just having them nearby gives me strength to overcome difficulties." P6 added: "I hope to find a stranger to talk to, someone I can reveal my inner worries to."

**Work and Life Security After Discharge:** Many participants discussed the scarcity of suitable positions for mental illness patients, expressing desire to return to work when stable to support themselves, reduce family burden, and achieve self-worth. P13 noted: "I feel we [mental illness patients] all crave stable work, but how to keep that job is a problem without solutions." P12 asked: "As a young person and family breadwinner, without work or income, how can family life be sustained? How can I afford medication?"

**Fair Treatment for Self and Family:** Family is crucial for young and middle-aged patients in remission, who strongly hoped their families would be treated normally rather than being discussed, discriminated against, or rejected. P11 expressed: "Others' harsh words don't bother me, but I'm afraid of burdening my family, especially my parents, wife, and children. I even worry about my children's future."

## Discussion

### Negative Emotional Experiences and Withdrawal Between Expectation and Behavior as Primary Manifestations

Negative emotional experiences and withdrawal between expectation and behavior represent key characteristics of social isolation in this population, consistent with findings from Fresán et al. [**?**]. The study revealed that after regaining insight, schizophrenia patients develop negative psychological emotions when confronting their illness. Faced with others' judgment, many use masking to conceal inner pain. These manifestations reflect both active social withdrawal and passive social avoidance. Simultaneously, patients desire communication with the outside world, yet experienced discrimination forces behavioral retreat or objective avoidance—termed "withdrawal between expectation and behavior." This subjective cognition and objective behavioral manifestation represents a forced social choice, serving as a psychological buffer for stigma and an act of reluctant acceptance.

For patients in remission, healthcare and community workers can adopt meaningful interventions such as group self-affirmation training [?], clubhouse rehabilitation models [?], and day rehabilitation center communication models [?]. By reducing perceived stigma, providing outlets for negative emotions, and increasing interpersonal opportunities, these approaches can improve stigma perceptions and social isolation. While medication and psychotherapy aid recovery, improving social function requires societal integration and learning through social life. Following the principle of "government leadership, multi-sector collaboration, and social participation" in mental health prevention, multi-departmental cooperation mechanisms involving local streets, community workstations, public security, civil affairs, and disability federations can provide community rehabilitation services, creating conditions for community integration and social return.

### Self-stigma and Self-alienation as Primary Internal Factors

Participants exhibited high levels of self-stigma, representing an internal cause of social isolation—consistent with Hu et al.'s research on people with HIV/AIDS [?]. Particularly for mental illness patients with recurrent episodes and repeated hospitalizations, pessimistic attitudes toward the outside world and future evolve into self-stigma. Rooted in illness-related inferiority, patients use masking and self-deception for comfort, confining themselves to comfort zones while viewing their existence as meaningless, worthless, and burdensome—sentiments widely prevalent among schizophrenia patients. Research shows that inferiority in young and middle-aged remission patients primarily stems from the mental illness diagnosis itself, with excessive attention to societal evaluation [?]. The fundamental cause of social isolation is strong inferiority leading to self-deception, self-avoidance, and self-negation. Under pervasive public perceptions, negative attitudes toward mental illness generate intense stigma, prompting patients to conceal their history, fear judgment from relatives and friends, and experience terror and anxiety about the future. These negative behaviors exacerbate stigma and trigger social isolation. Healthcare workers' negative attitudes toward schizophrenia patients can further intensify stigma, necessitating greater tolerance and privacy respect from medical staff and society. Therefore, future case management should target reducing relatives' stress [?] and implement peer support programs [?] to eliminate internalized stigma.

### Forced Alienation as a Primary External Factor

Forced alienation represents a major external factor in social isolation. After diagnosis, family and friends often subconsciously distance themselves from patients, while colleagues at work may inadvertently display aversion and discrimination. These factors variously intensify patients' alienation from society—a widespread and severe phenomenon that patients find difficult to accept. Discrimination, alienation, and aversion primarily originate from friends, colleagues, and neighbors. Sociocultural factors contribute to mental illness stigmatization, with the public basing attitudes on personal moral judgments and treating patients with aversion [?]. Many believe mental illness is divine punishment inflicted on "wrongdoers," while others consider it incurable, believing discharged patients should remain home rather than "endanger society." These misperceptions and negative attitudes create forced alienation.

Thus, mental health education is crucial. Hospitals and government departments can popularize schizophrenia knowledge through various channels, improving public acceptance and tolerance to create a friendly community environment for integration. Healthcare workers can reference multi-family group interventions [?] to improve patients' quality of life and family well-being, fostering a positive family atmosphere that reduces social isolation.

### Lack of Social Support as an External Factor

This study confirms that lack of social support is an external factor in social isolation, consistent with previous research [?]. After discharge, most young and middle-aged remission patients reside in communities with low return-to-work rates, often relying on informal employment. Inability to return to work or society gradually alienates them—a phenomenon widespread among participants. Most expressed that public stigmatization is common, urging greater national and societal attention and support, including adjusting and creating suitable positions enabling remission patients to work and earn income. Healthcare professionals should leverage their expertise to advocate for support from all sectors, fostering an inclusive social atmosphere.

Government strengthening of schizophrenia education can effectively guide public attitudes and reduce social isolation. Improving welfare systems, rights protection, and public support policies—such as employment assistance and medical aid funds—can facilitate better social integration. In conclusion, this analysis of 18 young and middle-aged remission patients identified three themes and eight sub-themes capturing the complex manifestations and causes of social isolation. Schizophrenia patients experience severe, lifelong social isolation requiring collective efforts to reduce internalized stigma and increase family intimacy. Comprehensive strategies including mental health education, improved medical services, diversified psychiatric care, strengthened human resources, and robust support systems are needed. Rehabilitation requires multi-sectoral collaboration and intervention to raise awareness and garner societal attention.

## Author Contributions

XU Yanan: Study design, interview data organization and analysis, manuscript writing and revision.
LI Wenjuan: Coordination of study implementation, literature review.
ZHAO Shuqin: Organization of interviews, interview data organization and analysis.
TANG Yuji: Literature review, organization of interviews.
YUAN Fuqiang: Interview data organization and analysis.
ZHAO Kunpeng: Interview data organization and analysis, manuscript writing

and revision.

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*Note: Figure translations are in progress. See original paper for figures.*