“If I Stay By Myself, I feel Safer”: Dilemmas of Social Connectedness among Persons with Psychiatric Disabilities in Housing First

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ABSTRACT

"If I Stay By Myself, I feel Safer": Dilemmas of Social Connectedness among Persons with Psychiatric Disabilities in Housing First

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Despite advances in mental health and housing interventions, social isolation among persons with severe mental illness (SMI), particularly among those who have experienced homelessness, continues to be high (Perese & Wolf, 2005; Hawkins & Abrams, 2007). Given that social attachment can be considered a fundamental need and that social connectedness is key to health, well-being, and recovery, it is imperative to understand why high levels of social isolation persist among persons with SMI. Whereas prior research has typically focused on how individual pathology undermines the ability of individuals to develop social connections, and how stigma leads to social exclusion, this study investigates the possibility that social isolation may also be addressed as a by-product of agency; that is, that it may result in part from a calculated decision-making process in response to the social conditions in which formerly homeless individuals with SMI live their lives.

Using grounded theory methodology, the study analyzes in-depth qualitative interviews at baseline and eight-year follow-up with participants who have SMI and are receiving housing and support services through a Housing First program. Interviews elicited individuals' experiences with their social networks and social interactions, while also capturing the perceived context in which these patterns of relating are embedded. The study sought to address the following research questions:

1: How do formerly homeless individuals with SMI describe their social connectedness and how does overall social connectedness change over time?

2: What are the factors that hinder social connectedness as reported by persons with severe mental illness?

3: What are the factors that facilitate social connectedness as reported by persons with severe mental illness?

In line with previous research (Hawkins & Abrams, 2007; Padgett et al., 2008; Tsai et al., 2012; Yanos et al. 2012), participants' social connectedness was generally low. Further, individuals appeared to make limited progress in the domain of social connectedness over the course of eight years. This was generally attributable to their underlying ambivalence regarding social connectedness. On the one hand, individuals valued the privacy and solitude of being at home and were content with spending their time alone; on the other, individuals also expressed concerns regarding loneliness and when discussing what was missing in their lives, the subject was overwhelmingly in the domain of social connectedness. Individuals' actions regarding social connectedness were generally characterized by social distancing – a purposeful limiting of social interaction - yet their desires still reflected a longing for close others.

Engaging in social distancing appeared to have developed in reaction to individuals' history of exposure to relationships that involved negative interactions, stress, and threats to personal freedom, resources, and recovery. Social distancing thus emerged as a strategy for minimizing exposure to risky situations and often occurred for practical reasons of self-preservation. Individuals described much of their social environments as characterized by poverty, prejudice, discrimination, and illicit activity,

which set the stage for problematic relationships and sustained social distancing. Many themes reflected upstream factors that influence people's opportunities to develop social relationships and likelihood of experiencing negative consequences, including residential segregation, racial discrimination, stigma, disability policies that yield inadequate incomes, poverty in general, and concentrated poverty in particular.

Despite depicting a fairly consistent picture of strained relationships, disadvantaged social conditions, and social distancing, the data also suggested several factors that prevented complete isolation for persons with SMI. These included connecting with aspects of their past, taking care of others, pursuing artistic activities, accessing distal neighborhood supports and resources, and having employment or volunteering. Further, maintaining or rebuilding relationships with past network members posed one of the few viable alternatives to social isolation.

Overall, this study suggests that social isolation among formerly homeless persons with SMI often reflected a lack of perceived opportunities for safe, stress-free, and supportive social affiliations, an issue that may be more a consequence of cumulative and concentrated disadvantage than a direct effect of mental illness (Draine, Salzer, Culhane, & Hadley, 2002). Given the benefits to quality of life that persons with mental illness derive from having their own homes through Housing First programs (Padgett, 2007; Yanos et al., 2004), addressing the broad factors that contribute to social isolation could increase connectedness and further enhance the effectiveness of this program model.

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DEDICATION

This dissertation is dedicated to my grandmother

Zora Sefer

and in memory of my grandparents

Ljiljana Stefancic
Miroslav Stefancic
Berislav Sefer

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CHAPTER ONE:

Introduction

Statement of the Problem

The social integration of individuals with severe mental illness (SMI) has re-emerged as a stated goal of policy and recovery-oriented services (New Freedom Commission on Mental Health, 2003; SAMHSA, 2009). In defining recovery from mental illness, the Substance Abuse and Mental Health Services Administration (SAMHSA) has highlighted community – "relationships and social networks that provide support, friendship, love, and hope" as one of four domains of recovery that also includes health, home, and purpose (SAMHSA, 2012). During this time, supported housing, and the Housing First approach in particular, has also been established as the leading program model for assisting persons with mental illness who need help with housing and support services. In contrast to traditional treatment models that emphasize transitional housing, treatment compliance, and clinician-driven services, the supported housing model - and the Housing First approach in particular - represents a significant paradigm shift that emphasizes permanent housing, consumer choice, and recovery-oriented services (Tsemberis, 2010). Despite advances in mental health and housing interventions, however, social isolation among persons with severe mental illness, particularly among those who have experienced homelessness, continues to be high (Hawkins & Abrams, 2007; Perese & Wolf, 2005). Persons with mental illness tend to have smaller social networks that are characterized by less frequent social interaction and less diversity of network members, with providers and family members

predominating (Albert, Becker, McCrone, & Thornicroft, 1998; Angell, 2003; Dailey, Chinman, Davidson et al., 2000; Townsend, Biegel, Ishler, Wieder, & Rini, 2006).

While supported housing has proven effective in reducing homelessness, increasing residential stability, and reducing psychiatric hospitalization (Rog, Marshall, Dougherty et al., 2014), there is little evidence supporting its ability to promote broader social integration. The few studies that have examined social integration among formerly homeless persons with mental illness have generally demonstrated that individuals make limited progress, even after receiving permanent housing and comprehensive support services (Tsai, Mares, & Rosenheck, 2012). With supported housing, we may have succeeded in finding a program environment that is "least restrictive" but lack of progress in certain domains, such as social integration, indicates that we are far off from creating an overall environment that can be considered the most enabling (Hopper, 2012). The apparent limited ability of supported housing programs to have a significant impact on individuals' social integration raises the question of what factors determine social integration and how can we improve these outcomes for persons with SMI.

In the field of sociology and health, social integration is most often examined as a predictor of health outcomes (Berkman, Glass, Brissette, & Seeman, 2000; Umberson & Montez, 2010), including mental health (Kawachi & Berkman, 2001; Turner & Turner, 1999). Studies find that low social connectedness, whether measured as low quantity (e.g., frequency of contact, number of relationships) or low quality (e.g., negative interactions, conflict), is generally associated with more adverse health outcomes, such as higher rates of morbidity and mortality (Berkman & Syme, 1979; House, Landis, & Umberson, 1998; Umberson & Montez, 2010), as well as poorer mental health (Seeman, 1996; Thoits, 2011). Much of the research has focused on identifying the pathways through which connectedness affects health, including investigating the

impact of social support on health behaviors and exposure to and/or management of stress, or how social ties affect basic physiological processes, among others.

While the effects of social integration on well-being are fairly well established, examination of what factors affect individuals' achievement of social integration is rare. Nevertheless, the few studies that have explored determinants of social integration have highlighted the potential for socioeconomic status (SES) to influence levels of connectedness (Mickelson & Kubzansky, 2003). Findings suggest, for example, that higher SES is fairly consistently associated with various aspects of social support (Krause & Borawski-Clarke, 1995; Roschelle, 1997). Given that social attachment can be considered a fundamental need and that social connectedness is key to health, well-being, and recovery, it is imperative to understand why high levels of social isolation persist among persons with SMI. An understanding of the factors that influence connectedness might then suggest how this might be corrected.

For populations diagnosed with severe mental illness, broader exploration of the determinants of social connectedness may be precluded by a heavy historical focus on mental illness and how individual pathology, combined with stigma, undermines the ability of individuals to develop social connections (cf. Perry, 2014 on the psychiatric perspective and modified labeling theory). Typically, work in this area has focused on mental illness as the main explanatory factor for isolation, emphasizing how the experience of the illness "damages" individuals' personal motivation or ability to interact with others and sustain relationships (Sundeen, 2000). Within this framework, social isolation comes in the form of impaired desire and skill for social interaction as a result of mental illness and social exclusion comes in the form of societal rejection as a result of stigma. Studies have demonstrated that negative symptoms of mental illness, in particular, are associated with smaller social networks (Hamilton, Ponzoha,

Cutler, & Weigel, 1989; MacDonald, Jackson, Hayes, Baglioni, & Madden, 1998; Meeks & Hammond, 2001).

So pronounced a focus on individual pathology, however, tends to potentially discount the profound impact of social conditions that may leave individuals vulnerable to isolation as well as the role of individual agency. Often missing from the literature is the "lived experience" (Miles & Huberman, 1994) of the individuals themselves, which seeks to capture and understand each person's situation from their perspective, including the subjective meanings and interpretations that they ascribe to various events. For the current study, it helps us to examine how individuals with SMI perceive their social environment, identify priorities, make trade-offs in light of competing interests and risks/benefits, and decide on ultimate courses of action (Archer, 2003). Through this type of qualitative research, we can construct what Williams and colleagues (2003) refer to as "knowledgeable narratives" that offer portraits of a "contextualized rationality…[which] direct us to acknowledge the ability of people to turn routine, taken-for-granted knowledge into discourse or narrative, and the need to find ways of interpreting the relationship between structure, context, and experience through a reading of these accounts" (pp.146-147). Specifically examining individuals' experiences and decision-making processes may lead to a better understanding of the factors that persons with SMI consider particularly relevant in determining whether and how to limit, maintain, or pursue social connectedness.

The few studies that have taken into account a context of endemic poverty among persons with mental illness suggest that social disadvantage may play a critical role in hindering connectedness. For example, Padgett and colleagues (2012) discussed the potential impact of cumulative adversity - multiple and chronic stressful life events and conditions such as poverty and trauma – on the recovery and connectedness of formerly homeless individuals with SMI.

Wilton (2004) documented how poverty negatively affects connectedness among individuals with SMI by precluding them from having funds to access resources (e.g., transportation) or opportunities (e.g., participation in leisure activities in the community) for sustaining or developing social relationships. Another study by Padgett and colleagues (2008) found that many individuals in this population maintained an "uneasy plateau" amid social disadvantage, struggling to maintain both recovery, particularly from substance abuse, and social connectedness. The experiences of homelessness and higher prevalence of substance abuse among persons with mental illness constitute other potential layers of difficulty, presenting their own challenges to connectedness (Alverson, Alverson, & Drake, 2001; Grigsby, Baumann, Gregorich, & Roberts-Gray, 1990).

Research Questions

Accordingly, this study seeks to explore how formerly homeless individuals with severe mental illness understand their social worlds and make choices with respect to limiting, maintaining, or pursuing social connectedness. Using grounded theory methodology, it analyzes in-depth qualitative interviews at baseline and eight-year follow-up with participants who have severe mental illness and are receiving housing and support services through a Housing First program.

Specifically, the project explored how individuals described their levels of social connectedness and their orientation towards social interaction and social relationships. It then examined the factors that hindered or facilitated their social connectedness. The study used a qualitative design to elicit individuals' experiences with their social networks and social interactions while also capturing the perceived context in which these patterns of relating are

embedded. In doing so, it sought to potentially identify a series of factors beyond mental illness that may perpetuate social isolation and undermine social connectedness.

The study sought to address the following research questions:

> **1:** How do formerly homeless individuals with SMI describe their social connectedness and how does overall social connectedness change over time?
>
> **2:** What are the factors that hinder social connectedness as reported by persons with severe mental illness?
>
> **3:** What are the factors that facilitate social connectedness as reported by persons with severe mental illness?

Whereas prior research has attributed isolation to defects or damages that mental illness imposes on the individual, this study investigates the possibility that social isolation may also be addressed as a by-product of agency; that is, that it may result in part from a calculated decision-making process in response to the social conditions in which these individuals live their lives.

Overview of the Dissertation

Chapter 2 reviews the relevant literature on mental illness, homelessness, and social connectedness. It emphasizes social connectedness as a fundamental life domain and documents the limited social connectedness experienced by persons with SMI. It discusses the paradigm shift in housing and treatment services for persons with SMI towards supported housing approaches, and the Housing First model in particular, with their focus on more normalized living arrangements and person-driven, recovery-oriented services. The continued shortcomings of current approaches to treatment and housing in significantly improving connectedness are noted. This is followed by a review of some of the shortcomings of the existing research, with

particular focus on the lack of attention to factors beyond mental illness in explaining social connectedness, including participants' perspectives on the social conditions in which they live and how these may influence connectedness. The introduction also presents study frameworks and theoretical background, with emphasis on Archer's (2003) framework that focuses on eliciting and capturing how individuals "deliberate about [themselves] in relation to [their] circumstances in order to plan for [their] future actions" (p.10). It then presents some of the previous studies that inform this study's questions and design. Chapter 3 presents the study design and methodology. It describes the initial study that utilized in-depth qualitative interviews to explore the topic of community integration among a sample of 24 participants who had severe mental illness and were participating in a Housing First program. It also describes the follow-up study which also consisted of in-depth qualitative interviews, with a focus on social connectedness, among 12 of the original 24 study participants eight years later. Modified grounded theory was used to analyze transcripts and develop overarching themes from both the original and follow-up study (Charmaz, 2006).

Chapter 4 reports study findings, first presenting appraisals of participants' social connectedness as well as participants' perceptions of their identities as social beings, and an assessment of change over time. This is followed by thematic findings regarding factors that can hinder or facilitate social connectedness. Given that participants' overall levels of social connectedness were fairly low, data were particularly rich for examining factors related to hindering connectedness. Further, given that changes over time in overall levels of social connectedness were generally limited among the follow-up sub-sample, thematic findings are presented uniformly irrespective of time-point, with a few exceptions where explicitly highlighting longitudinal changes was particularly illustrative. Finally, Chapter 5 ties findings

back to the existing literature and concludes with a discussion of the implications of the results for theory and practice, as well as the study's limitations.

CHAPTER TWO:

Literature Review

Introduction

As effective housing and treatment interventions enable individuals with severe mental illness to live in independent and integrated settings in the community, it becomes necessary to explore the "next step" challenges that they encounter in moving forward in their lives (Padgett, 2007). For many, this involves addressing the persistently high levels of social isolation among persons with mental illness, whose lives are often characterized by few social relationships, infrequent social contact, and low levels of participation in other domains of life, such as employment (Perese & Wolf, 2005; Rankin, 2005).

Historically, this question of "what's next" was largely absent in individuals' lives as the programmatic landscape for individuals with severe mental illness consisted largely of institutional or quasi-institutional settings geared towards custodial maintenance and explicit separation of these individuals from society. With deinstitutionalization, as individuals exited hospitals, some entered residential treatment arrangements in the community. These residences, while intended to maintain individuals out of the hospital, often served as mini-institutions, mandating adherence to highly structured living and treatment arrangements with few opportunities for broader community inclusion. In the past two decades, however, the notion that recovery from mental illness is possible has gained traction and brought a sense of hope that individuals with mental illness can have a "satisfying, hopeful, and contributing life" (Anthony, 1993) in the community like anyone else without psychiatric disability (Harding et al, 1987a,b). Parallel to the recovery movement, there has been a shift towards demonstrating that individuals who experience homelessness and severe mental illness can live independently in the community

and direct the course of their treatment and supports, regaining both stable housing and self-determination.

The Significance of Social Connectedness

Despite these advances, however, it is acknowledged that much of the lives of persons with severe mental illness continues to be characterized by social exclusion (Thompson & Rowe, 2010). Duffy (1995) defines social exclusion as "the inability to participate effectively in economic, social, political, and cultural life, and in some characterisations, alienation and distance from the mainstream society" (p.17). While low levels of participation in multiple domains of society characterize the lives of many persons with mental illness, there are several reasons for choosing social connectedness - "the construction and successful maintenance of reciprocal interpersonal relationships" (Ware et al., 2007, p.471) - as a critical starting point for examining exclusion. First, social relationships are a fundamental aspect of human lives, so much so that the desire for social attachment has been considered an inherent need (Bowlby, 1982; Baumeister & Leary, 1995). Social attachment is critical to development, particularly with respect to developing a sense of agency and trust in the world, two fundamental capacities upon which human action is based (cf. ontological security, Giddens, 1990). Second, deprivation in terms of social connectedness is particularly insidious and can foster further deprivation in other domains of social exclusion. In Nussbaum's (2000a) list of ten capabilities essential to human functioning, for example, affiliation is distinguished as being one of two capabilities that can "organize and suffuse all the others, making their pursuit truly human" (p.82). Thus, to be deprived of social affiliation is to be deprived of the very condition that pervades all other capabilities and of the human quality that infuses all actions.

Third, public health research has shown that social relationships play a key role in promoting well-being and can positively influence many other aspects of individuals' lives. Social relationships can be key to accessing resources, buffering stress, coping with problems, facilitating the adoption of health-promoting behaviors, and are associated with a host of beneficial outcomes including better mental and physical health (Kawachi & Berkman, 2001; Umberson, 2010). Conversely, social isolation is associated with a host of undesirable outcomes including increased morbidity, mortality, and poorer mental health and quality of life (Cornwell & Waite, 2009; House, 2001). For persons with psychiatric disabilities specifically, social relationships play a fundamental role in facilitating social integration, well-being, and recovery (Corrigan & Phelan, 2004; Davidson, Stayner, Nickou, Styron, Rowe & Chinman, 2001; Ware, Hopper, Tugenberg, Dickey & Fisher, 2008).

Fourth, low levels of social connectedness are especially pervasive for persons with mental illness. Studies have demonstrated that individuals with SMI tend to have smaller social networks (Albert et al., 1998; Baker, Jodrey, Intagliata, & Straus, 1993; Harris, Brown, & Robinson, 1999) and that wanting a friend has been rated as the highest unmet need (Perese, 1997). Network composition is also often limited, with service providers, others with mental illness, and a smaller proportion of family members predominating the networks (Angell, 2003; Dailey et al., 2000). Individuals tend to have less frequent contact with others and as a result spend much of their time by themselves (Davidson, Stayner, & Haglund, 1998). Time use studies indicate that individuals with SMI spend disproportionately more time in passive leisure activities and sleep, and less time in productive activities (e.g., work, volunteering, school) or active leisure compared with the general population (Krupa, McLean, Eastabrook, Bonham, & Backsh, 2003), though – importantly - differences are smaller when comparisons are made with

individuals from lower socioeconomic groups (Yanos & Robilotta, 2011). Subjective perceptions corroborate more objective measures, with many individuals reporting feeling lonely and dissatisfied with social support (Davidson & Stayner, 1997). Social contacts are particularly limited among those with psychiatric disabilities who tend to have substance abuse disorders and who are formerly homeless (Aubry & Myner, 1996; Hawkins & Abrams, 2007; Yanos, Barrow, & Tsemberis, 2004), with many reporting that they have no friends at all (Blankertz & Cnaan, 1994; Savage & Russell, 2005). Even when extent of connectedness is similar, comparisons of housed and homeless low-income women suggested that the networks of those who were homeless provided less positive support (Toohey, Shinn, & Weitzman 2004). Overall, the conditions of homelessness are characterized by many of the factors that are associated with loneliness among persons in general: poverty, unstable and challenging living situations, as well as disruptions of social relationships (Killeen, 1997). This limited social connectedness may come at great cost to persons with SMI as public health research has shown that social relationships play a key role in promoting well-being and can positively influence many other aspects of individuals' lives. Finally, while the definition of social exclusion is broad and multidimensional, this focus on connectedness is in keeping with most conceptualizations, which characterize participation in social activities as the primary marker of exclusion (Morgan, Burns, Fiztpatrick, Pinfold, & Priebe, 2007).

Many questions remain with respect to how this goal of inclusion might best be met, particularly when current public mental health services, in the main, often fall short of facilitating full inclusion, instead offering service users "program citizenship", a second-class status that becomes an enduring alternative to full participation in mainstream society (Rowe, 1999). Because traditional mental health programs are often viewed as undermining consumer

empowerment and choice, as well as constraining opportunities for broader social inclusion, one initial step has been to redesign mental health treatment and housing programs to eliminate barriers to social inclusion, most notably through the use of supported housing approaches such as the Housing First model.

The Paradigm Shift to Supported Housing: Housing First

In contrast to the traditional approach of serving individuals with SMI, the Housing First model attempts to remove traditional program barriers to inclusion by placing individuals in integrated housing settings (i.e., buildings not dedicated solely for individuals with SMI) and promoting empowerment and self-determination. Housing and treatment programs have traditionally made housing access and retention contingent upon compliance with psychiatric treatment, abstinence from alcohol and substance use, and observance of program rules, with most offering housing in the form of single-site community residential programs. In these programs, individuals are expected to demonstrate "housing readiness" by moving incrementally from the streets or from psychiatric hospitals through transitional housing and treatment arrangements that are intensively supervised, and eventually graduate to more independent housing. While successful with some segments of the population, the structure of these programs has been criticized for constraining individual choice, limiting rights of tenancy, and hindering inclusion by segregating individuals in housing that is solely dedicated for persons with psychiatric disabilities (SAMHSA, 2006). Programs frequently use coercive activities, leverage housing to maintain participation in treatment, mandate treatment compliance, and limit participants' ability to make choices regarding their lives (Allen, 2003; LeMelle & Monahan, 2007; Monahan, Redlich, Swanson et al., 2005).

Such housing and treatment approaches may have potentially damaging consequences on individuals' long-term personal attributes and competencies, such as sense of self-determination and empowerment, by denying individuals opportunities to make choices, take risks, and assume responsibility for mistakes or credit for successes. Program involvement can also have very real consequences in shaping opportunities for connectedness as programs have traditionally structured many of the social activities, interactions, and networks to which individuals are exposed (Browne & Courtney, 2004; Browne & Courtney, 2005; Dorvil, Morin, Beaulieu, & Robert, 2005). For example, one study found that the traditional residential treatment system leads to sexual isolation for persons with severe mental illness, largely because this system determines and greatly limits where, when, and to whom residents have access as potential partners (Wright, Wright, Perry, & Foote-Ardah, 2007). Further, to the extent that persons with severe mental illness continue to experience institutionalization and unstable housing, this can further dislocate them from their communities, thereby disrupting existing ties and individuals' ability to achieve developmental milestones during their life course (Shibusawa & Padgett, 2009). This is similar to Bury's (1982) conception of chronic illness as "biographical disruption" that signals "a biographical shift from a perceived normal trajectory through relatively predictable chronological steps, to one fundamentally abnormal and inwardly damaging" (p.171).

Rooted in principles of psychiatric rehabilitation (Anthony, Cohen, Farkas, & Gagne, 2002), the Housing First approach emerged in this context to offer a more client-driven solution to housing instability and treatment services (Tsemberis & Asmussen, 1999). It separates housing from clinical issues by addressing individuals' needs for housing *first*, providing them permanent housing without prerequisites for treatment and sobriety and then supporting them to

address clinical difficulties. Housing typically consists of scatter-site, independent apartments that are located in regular buildings in the community and that are accessible to persons without disabilities. Program participants have the same rights and responsibilities of tenancy as other persons who are governed by standard housing leases. Mobile support teams are based off-site and are consumer-driven: i.e., program participants are encouraged to choose their goals and to select the type, frequency and sequence of services, which are typically provided by multi-disciplinary Assertive Community Treatment (ACT) teams or Intensive Case Management teams (ICM) that have been modified to integrate principles of client choice and recovery (Salyers & Tsemberis, 2007; Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013). Program participants can refuse formal clinical services such as seeing a psychiatrist, taking medication, or working directly on their substance use, but most programs do require that clients meet with staff once a week as a "check-in" to assure the client's safety and well-being.

This focus on immediate access to independent housing, normalized living arrangements, consumer-driven services, and client self-determination is in contrast to the structure of traditional programs and partially accounts for how Housing First engages chronically homeless persons with mental illness who have been unable to access or progress through traditional services. Compared to control groups receiving services-as-usual through more traditional housing and treatment programs, participants in Housing First obtain housing earlier, remain stably housed at higher rates, spend significantly less time homeless and in psychiatric hospitals, and incur fewer residential costs (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Stefancic & Tsemberis, 2007; Tsemberis, Gulcur & Nakae, 2004). From the clients' perspective, Housing First and similar independent supported housing arrangements are associated with greater residential satisfaction (Siegel, Samuels, Tang, Berg, Jones, & Hopper, 2006), greater

independence (Yanos, Felton, Tsemberis, & Frye, 2007), and greater choice (Nelson, Sylvestre, Aubry, George & Trainor, 2007), which leads to decreased psychiatric symptoms, partly as a result of an increased sense of mastery (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005). Further, moving into independent housing has been associated with significant improvements in satisfaction with overall quality of life, as well as improvements in housing satisfaction (the latter outcome was not observed for more dependent residential settings) (Wolf, Burnam, Koegel, Sullivan, & Morton, 2001). With research demonstrating positive housing outcomes, the Housing First model has been recognized by SAMHSA as an evidence-based practice (SAMHSA, 2014) and has been replicated in over 100 cities throughout the U.S. as well as in Canada, Europe, and Australia. With this proliferation of programs, it is necessary to explore the next-step challenges and opportunities that successfully re-housed persons with mental illness may encounter as they make the shift from homelessness towards social inclusion.

This study examined social connectedness among participants of a Housing First program for several reasons. Social isolation is thought to pose a particular challenge for persons in Housing First programs, where clients most often live in scattered-site housing without ready access to the social opportunities and supports found in supervised congregate residences (Yanos, Barrow, & Tsemberis, 2004). On the other hand, because Housing First programs minimize the degree to which client self-determination and choice may be constrained by the program itself, participants' perceptions, desires, and decisions may be more reflective of their actual perspectives rather than program mandates. Given normalized living arrangements and program requirements that minimally restrict individuals' freedom and mobility (e.g., weekly contact with service providers, paying 30% of income toward rent), while promoting self-

determination, the potential for inclusion is arguably similar to that of any other neighborhood resident.

As noted previously, however, studies of social integration outcomes among participants in Housing First and similar supported housing arrangements have been underwhelming, though short follow-up timeframes may partially account for a lack of significant changes over time. Despite the removal of program restrictions in Housing First, at least one study suggests that after exiting homelessness, neither Housing First nor traditional program participants expanded their social networks in a significant way, at least in the short-term (Henwood, Stefancic, Petering, Padgett, & Abrams, n.d.). Another one-year longitudinal study reported limited improvement in terms of overall social integration among homeless individuals post-enrollment into supported housing and described the sample as "socially marginalized and isolated" (Tsai et al., 2012, p.433). In that study, an initial finding of a small but statistically significant increase in physical and social integration was negated when controlling for changes in symptoms. Another study found that program housing type was not associated with different aspects of community integration (Yanos, Felton, Tsemberis, & Frye, 2007). Further, qualitative research suggests that cumulative adversity and/or living in concentrated disadvantage adversely affects participants' ability to maintain or pursue positive social relationships and that negative social interactions or networks can play a significant role in the lives of formerly homeless individuals with mental illness and substance abuse problems (Hawkins & Abrams, 2007; Padgett, Henwood, Abrams, & Drake, 2008; Wilton, 2003). Given that removing program barriers to connectedness may be necessary, but not sufficient, it is imperative to explore other factors that may influence social connectedness beyond program variables.

Limitations of Existing Research on Social Connectedness and Mental Illness

Given that social relationships are often placed at the forefront of individuals' progress towards recovery, it is essential to explore the factors that may contribute to isolation or engagement among persons with severe mental illness (Anthony, 1993; Spaniol, Bellingham, Cohen, & Spaniol, 2003). To do so, however, means first confronting a number of potentially distorting premises in the conventional literature. Much of the literature regarding persons with psychiatric disabilities has implicitly taken mental illness to be the primary explanatory factor for isolation; in that tradition, it seems self-evident that persons experiencing illness have reduced ability for social affiliation. The belief within this dominant framework is that the experience of mental illness "damages" individuals' personal motivation or capacity to interact with others and to sustain relationships by negatively impacting social skills, cognitive abilities, and desires for social affiliation (Davidson, Stayner, & Haglund, 1998; MacDonald et al., 1998; Miller & Flack, 1990). So pronounced a focus on the role of the actual illness, however, tends to discount (and so underestimate) the profound impact of other social conditions that may leave individuals vulnerable to isolation. Draine and colleagues (2002) similarly critique the literature connecting mental illness to other problems such as homelessness or criminal justice involvement, noting that researchers "have frequently failed to recognize that the experience of people with mental illness is often contextualized in disadvantaged social settings" (p.565). They go on to suggest that, "mental illness is not as potent an explanatory factor…as the psychiatric literature might lead us to believe" (Draine et al., 2002, p.565). This reflects a larger pitfall of some domains of public health research that points to individual characteristics as risk factors or utilizes more narrow clinical perspectives for examining problems that are, at least in part, socially produced (Meyer & Schwartz, 2000).

A less pathologizing view of social isolation was explored by Corin & Lauzon (1992), who conceptualized it as "positive withdrawal," a process of retreating from social roles and relationships in order to participate in a "larger restructuring process." Here, isolation signifies a strategic retreat from social demands during which individuals seek meaning, reconstruct the self and their identities, and build up inner strength for future social interactions and deeper attachments. During this time, individuals may engage in low-intensity interactions or simply maintain a presence in public spaces among other individuals, without being expected to engage with others. These "occasions" are seen as rehearsals, preparing the individual for broader social interaction once they are ready. This stage of social integration is similar to Strauss and colleagues' (1985) concept of "wood shedding," which denotes a phase of recovery during which an individual does not appear to be making outward gains, but is slowly accumulating the resources and competencies needed for broader connectedness. While offering a more restorative and less pathological interpretation of the function of isolation, as well as re-valuing agency, it continues to place the focal point on personal deficits, with individuals needing to develop socially and psychologically in preparation for the pursuit of social connections.

Second, and related, is the relative inattention to the social experience of persons with severe mental illness living in community settings (Kloos & Shah, 2009). While slowly expanding, research has largely focused on identifying how physical aspects of individuals' housing impact outcomes (Kloos & Shah, 2009; Newman, 2001). Largely missing from the literature is the "lived experience" of the residents, as well as the larger neighborhood social context. This lack of focus on the influence of environmental conditions, as Kloos & Shah (2009) note, is largely due to the lack of a framework that takes into account both the physical and social aspects of a person's environment, as well as one that acknowledges that the person

actively interacts with their environment (e.g., goodness of person-environment fit). A framework is needed, therefore, that would tie together both the person and their social context. Additionally, studies continue to focus on individuals' neighborhoods of residence as primary determinants of individual outcomes, yet for many these neighborhoods are no longer the locus of their social activity (Carrington & Scott, 2011; Wellman, 1979). An open-ended approach, that is more inclusive in its conceptualization of integration by removing the traditional, but outmoded, geographic boundaries associated with definitions of community, would be beneficial.

A further bias in the mental health literature is a focus on examining social relationships solely for their beneficial effects, a bias that reflects an overwhelming trend found in general research on social support. The lack of attention to the negative consequences of social relationships is highly problematic, with few researchers examining how experiencing negative social interactions affects individuals (Yanos, Rosenfeld, & Horowitz, 2001). This is consequential because, as a recent review suggests, "negative social interactions may, in fact, have more potent effects on psychological well-being than positive interactions" (Lincoln, 2000, p.232). This review demonstrated that 19 out of 26 studies reported that negative social interactions had a greater impact on psychological well-being than positive interactions and another six found an equal impact (Lincoln, 2000). The negative effects of social interactions are reflected in the psychological distress that they cause and how they "hinder goal-directed activity, erode perceived self-efficacy, disrupt problem-solving, pose a threat to self-esteem, and interfere with the use of resources" (Lincoln, 2008, p.224). This more balanced understanding of social relationships and interactions both enriches and complicates the task of investigating the determinants and consequences of social connectedness. Given that relationships may resist easy

categorization as positive or negative and that social interactions may simultaneously encompass both benefits and drawbacks for the individuals engaged, it is important to understand both the determinants and potential consequences of social connectedness.

Theoretical Frameworks

As a partial corrective to such tendencies, and in order to provide a broader understanding of the factors that may influence social relationships and their consequences, this study embeds the problem of social isolation within the larger debate on the influence of structure vs. agency on human behavior. It recognizes that structural features can constrain or enable individual behaviors, making certain courses of action more or less likely. At the same time, it also embraces the idea, as Archer (2003) notes, that individuals "deliberate about [themselves] in relation to [their] circumstances in order to plan for [their] future actions," and that for some this self-reflection can involve a social, interactive process (p.10). Such a framework calls for exploring how individuals perceive their objective circumstances, identify priorities, make trade-offs in light of competing interests and risks/benefits, and decide on ultimate courses of action. *Accordingly, this study seeks to explore how formerly homeless individuals with severe mental illness understand their social worlds and make choices with respect to limiting or pursuing connectedness.* It thus moves beyond the traditional framing of viewing persons with mental illness as pathologized agents who lack basic capabilities for social interaction, problematizes the presumed value of connectedness, and reclaims a role for indigenous voice in understanding the issue.

The approach taken here recognizes that individual attributes and competencies related to mental illness may affect individuals' deliberative abilities as well as the degrees of connectedness that individuals can achieve. At the same time, it proposes that psychiatric

disability intersects with other structures of stratification, such as class/SES, race/ethnicity, gender, and age to create different "fields of disadvantage" within which individuals pursue social connectedness. As many theorists argue, while individuals may choose to adopt certain behaviors – e.g., to seek out or limit social interaction – the social circumstances in which they live may very well bend them preferentially in the direction of these choices (Frohlich et al., 2001; Cockerham, 2005). In part, this occurs because such circumstances largely determine the types of "associational opportunities" that are available (Huckfeldt, 1983), along with their concomitant risks and benefits. The study seeks to describe how individuals navigate these "structural" fields, and does so from the perspective of the individuals facing the challenge. Analysis of participants' reconstructed explanations of social connectedness in context can reflect the choices that they make and how they manage social interactions and relationships. The choices and strategies that individuals adopt can subsequently affect the degree to which they experience social connectedness.

Reflecting conceptual frameworks that have been utilized in much research within urban sociology, this study opens the possibility that social connectedness may be influenced "by the conditions under which [people] are living, or the behavioral choices open to them as a result of these conditions" (Gans, 1990, p.272). In public health research, Link & Phelan (1995) likewise emphasize that proximal causes of individual behaviors are rooted in social contexts and that it is necessary to understand what places individuals "at risk of risk." It is also important to avoid, however, an overly deterministic argument that negates the "powers and properties" of people as agents (Archer, 2003). Thus, in writing about African American youth and coping strategies, Spencer (2001) states:

> The ways in which [individuals] perceive their environments and cope with contextual stressors mediate the relationship between structural barriers and outcomes…If we can

> understand the perceptual processes then we can design developmental and culturally sensitive interventions for promoting competence and success in spite of structural barriers (p.53).

For example, objective neighborhood social conditions such as high criminal activity may be associated with residents being less likely to venture outside their apartments to interact with others. At the same time, however, an individual resident may have to perceive the neighborhood as dangerous in order for the neighborhood to have a limiting influence on social behavior; or, despite these perceptions, some may still choose to seek social interaction. In line with social ecology theory, this study seeks to "understand the experience of the environment from the individual's perspective" (Kloos & Shah, 2009, p.326). To do so, it utilizes qualitative data from in-depth interviews with formerly homeless persons diagnosed with SMI as a window into those "internal conversations" that, as Archer argues, are a primary mediating link between structure and agency.

These deliberative practices (some of which occur as internal, others notably as externalized conversations) involve ordinary people exploring considerations about how they would or did act in certain instances, given who they are and their external circumstances. Archer proposes that these conversations can be elicited in interviews and examined to reveal the interplay between structure and agency. While they may include misrecognitions or miscalculations, these too can be further analyzed by the researcher – "The whole enterprise involves the interpretation of interpreting subjects" (Archer, 2003, p.154) – and thus the rationales produced offer an informative, if incomplete, depiction of how practical reasoning unfolds. Specifically, this project will critically examine the "felt" limitations, challenges, and facilitators reported by individuals with severe mental illness who were once homeless but are

now living in their own apartments and receiving support services through a Housing First program.

Qualitative methods have been previously used to inform this type of sociological inquiry. In seeking to understand health behaviors and choices in an inner city area in England, for example, Williams and colleagues (1995) used participant narratives to try and capture individuals' perceptions of what places them at risk for adverse health. The researchers' appraisals of participant data are worth quoting at length:

> "the narratives produced were undeniably knowledgeable, theoretical, and discursive…What people know…co-constitutes the world as it is, and helps social scientists to understand how structures determine health and wellbeing through contexts and practices…we explore 'lay knowledge' as a way into theorizing the structure-agency problem…'knowledgeable narratives'…contextualize explanations and connect context to composition, places to people…[they] illustrate the need to contextualize risks…by reference to the wider material and environmental conditions in which risks are embedded…These lay narratives...[are] complex bodies of contextualized rationality that are central to our understanding of social structure and its impact…they do direct us to acknowledge the ability of people to turn routine, taken-for-granted knowledge into discourse or narrative, and the need to find ways of interpreting the relationship between structure, context, and experience through a reading of these accounts" (Williams, 2003, 146-148).

The current study seeks to similarly capitalize on individuals' ability to share this "lay knowledge" with respect to social connectedness. It utilizes Archer's (2003) framework to avoid a common duality found in research that tends to examine properties of either structure or the agent. As such, this study does not focus on identifying objective social conditions in which individuals live (e.g., what neighborhood assets or resources are available to residents) nor does it focus on personal deficits (e.g., how symptomatic a certain individual may be). Instead, it examines how individuals "critically evaluate and choose their course of action" based on perceptions of themselves and their social circumstances (Cockerham, 2005, p.60). This study recognizes that not only individual abilities, but also social conditions can have a cumulative

impact on individuals' preferences and actions. For example, beliefs that persons with mental illness prefer to be alone usually ascribe these preferences to individual attributes and rarely take into account theories such as adaptive preferences, colloquially known as "sour grapes." The theory of adaptive preference formation stipulates that individual preferences are partly a function of a history of interacting with particular social circumstances. Individuals who desire something, but find it unattainable given their social environment, may shift their beliefs to devalue the initially desired object (Elster, 1982). It can also be used to explain the absence of any initial desire, if one has never lived in circumstances that would have fostered the desire in the first place (Sen, 1985). As Sen (1987) states, preferences and commensurate behaviors may simply reflect a situation where an "underdog comes to terms with social inequalities by bringing desires in line with feasibilities" (pp.10-11). Adaptive preference can thus serve as a defense mechanism that pre-emptively reduces cognitive dissonance by shifting one's values and identity – one's felt desire - to be in line with the status quo of deprivation. It further allows the individual to preserve a sense of self-determination and self-esteem by providing a rationale for the "choice" Thus, while preferences for being alone may reflect individual traits or abilities, they may also be a function of cumulative exposure to conditions that pose challenges to social connectedness. These enveloping conditions and histories can become "embodied," directly shaping individuals' internal deliberative processes and behaviors (Krieger & Davey-Smith, 2004).

Social Disadvantage and Connectedness

Social conditions and mechanisms such as poverty and inequality, prejudice and discrimination, and residential segregation may play a role in setting the context for the choices people make. Indeed, several studies of the general population have found that persons of lower

socioeconomic status tend to achieve lesser degrees of connectedness (House, 1987; Marmot, 2004; Marsden, 1987; Roschelle, 1997; Tigges et al., 1998). Further, in a study investigating the association between social support and socio-demographic characteristics, a critical financial threshold was reported. The study found that, "only those making less than $20,000 a year reported significantly less emotional support, more negative interactions, and less contact with friends, whereas there were no differences on social support across the other income categories" (Mickelson & Kubzansky, 2003, p.272). The researchers also concluded that "the strongest evidence to date finds that economic deprivation *decreases* availability of support resources, despite the culturally strong value placed on social support among many social disadvantaged groups" (p.266).

Findings from a study that compared community integration among a sample of participants with SMI in a Housing First program to a sample of persons without psychiatric disability are also informative in highlighting the potential role of social disadvantage versus symptoms for connectedness. That study recruited Housing First participants and community members from the same neighborhoods and the two samples did not differ significantly in gender, race-ethnicity, education, recent criminal justice involvement, or recent drug use (Yanos, Stefancic, & Tsemberis, 2012). While differences in mean monthly income were statistically significant, both groups were living in poverty and the actual difference was fairly small, amounting to $65 a month ($772/month for Housing First and $837/month for the community sample). In terms of outcomes, the two groups did not differ in their levels of psychological integration, measured as sense of community and life satisfaction. Neighborhood factors, including both objective and perceived neighborhood characteristics, affected psychological integration among participants with mental illness, but symptoms did not. With respect to

objective indicators of community integration, measured by participation in various activities outside the home as well as frequency of interaction with community members which have more direct overlap with social connectedness, the sample of persons without psychiatric disabilities scored significantly higher on all indicators of community integration. The authors also concluded, however, that

> differences were relatively small, and on the whole, community integration was low for both groups. This finding may reflect that both groups had similar educational and racial-ethnic backgrounds, which may indicate similarities in culture and lifestyle. Both the consumer and community samples met objective criteria for poverty and lived in disadvantaged communities, which also may have restricted the range of possibilities for community integration" (Yanos, Stefancic, & Tsemberis, 2012, p.443).

The study also found that symptoms were not "a major factor in impeding community integration…" (Yanos, Stefancic, & Tsemberis, 2012, p.443). Similarly, a study of persons with psychiatric disabilities found that they differed significantly in satisfaction with all domains of social support when compared to the general population, but not when compared to a non-psychiatrically disabled group of welfare recipients (Caron, Tempier, Mercier, & Leouffre, 1998).

Several qualitative studies also lay the groundwork for the inquiry pursued here. Hawkins and Abrams (2007) found that among formerly homeless individuals with psychiatric disabilities, social networks were particularly small due to premature deaths among network members, individuals with mental illness creating difficult situations that led to a severing of ties, and network members having few resources to offer each other. That study also concluded that some participants engaged in social distancing as a means to protect themselves from further betrayal, disappointment, or peer pressure. Wilton (2003) also documented how individuals with mental illness living in poverty struggled to meet basic needs. Individuals' insufficient incomes

significantly undermined their ability to maintain connectedness with family and to establish relationships with others.

Study Objective

Whereas much prior writing attributes social isolation among individuals with psychiatric disabilities to the defects that mental illness imposes on the individual, this study investigates the possibility that social isolation may also result in part from calculated decision-making processes in response to the real conditions in which these individuals live out their lives. While acknowledging that stigma with respect to mental illness is one of the more common factors considered to influence social connectedness in this manner (such as when individuals purposefully isolate to avoid negative encounters or rejection by others explicitly on the basis of indicators of mental illness) (Corin & Lauzon, 1992; Goffman, 1963), the study explores whether other aspects of individuals' social worlds can place individuals with SMI at risk for social isolation and further exacerbate the potential for individuals to engage in social distancing as a means to manage these risks.

CHAPTER THREE:

Research Design and Methodology

Study Design and Rationale

The research questions will be answered by analysis of qualitative interview data from a study of participants with SMI living in apartments and receiving Housing First services. There are several reasons for choosing qualitative methods to conduct an inquiry into social connectedness among persons with mental illness. First, qualitative methods can capture the "lived experience" of the respondents, yielding data that represent their understanding of social phenomena and how they create meaning from it. This approach does not necessarily seek to capture an objective reality, but rather seeks "to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 2004, p.2). Second, with rich, in-depth descriptions of social phenomena, qualitative research is particularly well-suited for understanding social processes in context (Bartlett & Payne, 1997). This is critical, given the aim to understand how participants' practices with respect to social connectedness may be informed by their perceptions of social conditions, as well as aspects of social disadvantage. With respect to the project's framework, qualitative methods will allow for an exploration of how participants perceive issues relating to their SES or living conditions as relevant in facilitating or constraining social contacts. Examining participants' practical reasoning for seeking or avoiding social contact can be used to trace potential paths to the social conditions of their everyday lives and how they influence decisions that participants have to make with respect to social encounters. Finally, by investigating the factors that participants perceive as facilitating or impeding connectedness, qualitative findings can complement quantitative findings (Padgett, 2012). They can offer explanations for why social connectedness is generally low for persons with mental

illness, as well as uncover how for different sub-groups - despite exhibiting similar degrees of connectedness - similar processes may manifest in different ways.

The study analyzed qualitative interviews conducted with Housing First program participants. Data consisted of 1) baseline interviews conducted with Housing First participants, previously collected as part of a larger research study exploring community integration among individuals with psychiatric disabilities; and 2) follow-up interviews, that took place approximately eight years later, with a subset of participants who could be located from the original study. The aim of the original study was to explore community integration among persons with SMI in Housing First. In line with previous research (Wong & Solomon, 2002), that study examined community integration as a multi-dimensional construct, operationalized as the extent to which individuals engaged in activities outside of their home, engaged in social interactions with others, and had a sense of belonging in their neighborhoods or other communities. The study was designed, therefore, to explore the degree to which participants were achieving community integration, in terms of how they integrated physically, socially, and psychologically. Interviews completed for that study were never analyzed and presented an excellent opportunity to explore how participants perceive social relationships and how they describe choices made with respect to social connectedness. The interviews asked individuals to describe their daily activities, social interactions, and living conditions, thus obtaining information on the social context of individuals' lives that is so often missing from research on isolation. The baseline sample consisted of 24 participants, each of whom completed one semi-structured qualitative interview between February and April 2005.

Given that the original study was not explicitly designed to explore the factors that hindered or facilitated social connectedness, questions arose as to whether the research questions

could be meaningfully answered by the available data. There is substantial conceptual overlap between the baseline study's focus on community integration and this dissertation's emphasis on social connectedness. Community integration is typically defined as the extent to which an individual perceives a sense of belonging in a community, engages in activities outside the home, and interacts with others (Wong & Solomon, 2002). These aspects are important indicators of, or precursors to, social connectedness. For example, developing social relationships may be predicated on a sense of belonging, and participation in community activities may consist of opportunities for social interaction. The similarity between community integration and social connectedness was further maximized in this study by the fact that baseline interviews explored participants' integration beyond their neighborhoods of residence, attempting to capture their broader social involvements. In addition to this conceptual alignment, preliminary analyses were conducted on baseline interviews to ensure there would be sufficient data to address the questions posed by this inquiry and to assess the potential for "evidentiary adequacy" (Erickson, 1986; Morrow & Smith, 1995; Morrow, 2005). This preliminary analysis focused, therefore, on questions such as whether there was a sufficient amount and variety of data to address the proposed inquiry and concluded that the data were adequate and informative.

The follow-up study focused on exploring areas that were identified from preliminary data analysis of baseline interviews as particularly relevant to exploring social connectedness. At baseline, all participants had given permission as part of informed consent to be contacted regarding possible future interviews. Data collection for the follow-up study occurred between December 2012 and March 2013. The original study protocols were reviewed and approved by the Institutional Review Board of the Housing First program. This study was approved by both the Columbia University IRB and the Housing First program's IRB.

Sampling and Recruitment

The baseline sample consisted of 24 participants. Eligibility criteria included individuals who were 1) 18 or older, 2) diagnosed with a severe mental illness, and 3) enrolled in the Housing First program. The original study combined maximum variation and convenience sampling strategies to recruit participants. To understand both individual and neighborhood factors that may affect integration, the study sought a sample of participants that differed with respect to individual background characteristics and location of residence. While the ability to capture variation was limited given the small sample size, participant recruitment strategies focused on generating a sample of participants who differed with respect to gender, race/ethnicity, age, and neighborhood. Participants were recruited by interviewers who visited four different service locations of a Housing First program in New York City and invited clients who were present to participate. As the sample accrued, interviewers were instructed to either stop or intensify recruitment for participants fitting certain sampling criteria.

Approximately eight years after the baseline interviews were conducted, attempts were made to locate the original study participants to invite them to participate in a follow-up study. Follow-up attempts included searching program databases for last known contact information and asking program staff with extensive institutional knowledge of the program for participants' potential whereabouts. Of the 24 participants, 3 (13%) had passed away in the interim, 8 (33%) had been discharged from the program and could not be located, and 13 (54%) were still in the program and successfully contacted. Of those who were successfully contacted, all expressed interest in participating in the follow-up; however, one participant missed three interview appointments and so follow-up interviews were completed with 12 participants[1]. Of the 8

[1] Issues of adequacy of the follow-up rate are discussed under "Limitations"

participants who were discharged, five were characterized as negative outcomes: two had experienced long-term psychiatric hospitalizations, one was serving a long-term jail sentence, and two requested to be discharged after being evicted from their apartments (one re-located out-of-state despite being offered another apartment and the other declined more supervised housing options after multiple evictions from apartments). The outcome of one participant's discharge was unknown because the individual did not return to the housing program, as initially planned, after completion of a long-term substance use rehabilitation program. Another discharge was mixed as the participant abandoned her housing and declined to be re-housed (where she was staying was unknown), but she was also able to graduate to a less intensive level of care. The final discharge was positive as the participant graduated to a lower level of care and maintained his housing of choice (a shared apartment with a supportive member of his social network).

Data Collection

Research interviewers were psychology or social work graduate students who received rigorous training from the author in qualitative interviewing methods and techniques, and who had previous experience with recruitment and consent procedures for persons with SMI. Baseline interviews were completed at program offices or in participants' homes, depending on participant preference, and only after participants provided signed informed consent. The baseline study used an interview guide with open-ended questions relating to participants' daily activities, the people they saw on a regular basis, their perceived fit in their neighborhood, where they felt most at home, and what was missing in their lives, among others. The interview guide included both questions and suggested probes, and was refined based on two pilot interviews. Interviewers were instructed to cover core topic areas, but were free to probe and maneuver through the guide as they deemed appropriate. To increase rigor during data collection and guard

against bias, the author led weekly peer support debriefings with interviewers to discuss interviews, recruitment, and to reflect on the research process (Padgett, 2012).

While an iterative process of data analysis and data collection did not occur within data cycles as is consistent with grounded theory, preliminary analysis of baseline interviews informed the design of the follow-up interview (Glaser & Strauss, 1967). This allowed the follow-up interviews to explore more in-depth relevant domains and to refine emerging concepts and theories from baseline. Follow-up interviews were also completed at program offices or in participants' homes, depending on participant preference, and only after participants provided signed informed consent. The follow-up interview guide consisted of open-ended questions pertaining to what is important in participants' lives; people, activities, and places with which participants are, were, or would like to be involved; challenges they face; and what is going well. Sample questions included: "Tell me about some of the important people in your life right now," "Are there people that are or were important to you, but with whom you're not in contact?", "Tell me about some of the places that you go to or activities that you do in/outside your neighborhood," "Are there places you used to go to or things you did that you don't do any more?" and "What's missing in your life?". Similar to baseline, the interview guide included both questions and suggested probes and interviews were flexibly structured so as to facilitate more natural conversation that covered the necessary topics vs. explicitly following a script and sequence. Participants received $25 in compensation for their time at baseline and $30 for their time at follow-up. Baseline interviews lasted an average of 45 minutes and follow-up interviews lasted one hour, on average.

All interviews were digitally audio-recorded and transcribed verbatim by interviewers or the author for analysis. All participant files were identified by an ID number and the file

matching participant names to ID numbers was stored separately in a double-locked cabinet. Hard copies of material associated with participant data (e.g., transcripts, summaries) were stored in a double-locked cabinet and electronic files were stored on a password-protected computer.

Participants

Baseline participant characteristics are presented in Table 3.1 Single female adults generally constitute a smaller percentage of consumers served by Housing First programs and so efforts were made to over-sample women to capture the perspective of female participants. Nevertheless, the sample was overwhelmingly male. Because consumers in the Housing First program, and in the chronically homeless population in New York City generally, tend to be of minority racial/ethnic status, the sample was also largely Black/African-American. Just over half (n=14) had completed at least a high school/GED education. Participants' tenure with the Housing First program varied widely, spanning 2 to 12 years. All participants were diagnosed with an Axis 1 mental illness, most commonly schizophrenia or schizoaffective disorder and 17 also had diagnoses of substance use disorders. Most participants (n=19) had spent at least two years homeless and the median number of psychiatric hospitalizations was five (ranging from 0 to 25).

A subset of the baseline participants comprised the follow-up sample. These 12 participants were 9 men and 3 women. The majority still had a diagnosis of schizophrenia or schizoaffective disorder and a substance abuse disorder. Six (35%) of the original 17 male participants and 2 (28%) of 7 female participants were discharged and could not be located. Two of 17 male participants and 1 of 7 female participants passed away.

Table 3.1 Participant Characteristics, N=24

Characteristic	N or Mean (range)
Gender	
Male	17
Female	7
Race/Ethnicity	
African-American/Black	14
Caucasian/White	3
Latino/a	3
Mixed/Other	4
Age	44 (28-72)
Time in Program	5.3 years (2-12)
Primary Diagnosis	
Schizophrenia or Schizoaffective Disorder	15
Major Depression	4
Bipolar Disorder	2
Other Axis I	3
Substance Use Diagnosis	
Yes	17
No	7

Data Analysis

The study used a thematic analysis approach, similar to that described by Boyatzis (1998), rooted in grounded theory. Thematic analysis is "a process for encoding qualitative information" (Boyatzis, 1998, p.vi) and organizing data into meaningful categories (Padgett, 2012). It represents an approach to perceiving, labeling, and interpreting patterns in raw data such as qualitative interviews. Transcripts from 24 participants at baseline and 12 participants at follow-up constituted the data sources for this study.

Based on these transcripts, case summaries of each participant were developed for each time-point as a way to condense the data and "derive a coherent, overall account" of each participant's interview (Miles, Huberman, & Saldana, 2014, pp.131-132). These case summaries included information related to participants' social relationships, activities in and outside the neighborhood, descriptions of their neighborhood and building, and issues related to drugs, work, and mental and physical health, as well as program involvement. Noteworthy quotes were also included in each case summary.

From these summaries, a case summary matrix was developed (Miles & Huberman, 1994). This matrix represented a table template that was conducive to further synthesizing relevant data from each participant. The table included categories that summarized each participant's involvement with children, family, friends, peers, providers, and others; their perceptions of themselves and their subjective evaluation of their degree of connectedness (e.g., "loner"; "prefer being by myself") as well as basic demographic information. Consisting of "telegraphic-style phrases boiling down coded chunks from the case data," the case summary matrix served as a "data-condensing device for distilling hundreds of pages of text into workable, intellectually coherent units" (Miles et al., 2014, p.136). Utilizing the case summaries and data

matrix, participants were categorized as having low, medium, or high social connectedness. For the subset of participants with follow-up interviews, changes in social connectedness over time were also identified. Given that social connectedness is considered a multi-dimensional construct, this study took into account both aspects of the quantity and quality of social relationships and interactions (Umberson & Motez, 2010). Aspects of quantity included more objective indicators, such as number of network members and frequency of contact, and quality features included more subjective indicators such as the quality of interactions or of the support exchanged (House, Umberson, & Landis, 1988; Umberson & Montez, 2010). Research has demonstrated that both aspects are important for well-being, even though they may operate somewhat independently (Cornwell & Waite, 2009). Beyond potential close relationships, such as with friends, family, or peers, the presence of "distal support" (Wieland, Rosenstock, Kelsey, Ganguli, & Wisniewski, 2007) was also taken into account. This type of connectedness represents "casual, routine interactions with community members" and is associated with both community integration and recovery (Townley, Miller, & Kloos, 2013).

Thematic analysis proceeded in a series of steps: 1) developing initial codes (open-coding), 2) validating & using the codes (i.e., coding all transcripts with a final code list) and 3) clustering and interpreting the codes, and developing broader themes. Because qualitative data analysis requires the researcher to interpret participants' reported experiences and meanings, thereby blurring the lines between "objective reporting" and "intersubjective understanding" (Olesen, 1994), the credibility/authenticity and trustworthiness of a study have been identified as critical to judging the rigor of qualitative research (Lincoln & Guba, 1985). Strategies to enhance rigor are, therefore, discussed for each stage of the completed analysis.

The first step of analysis – open coding - used an inductive or data-driven approach to develop a preliminary code list (i.e., labels that describe chunks of data in a conceptually meaningful way) (Strauss & Corbin, 1990). This was accomplished by reading several transcripts thoroughly and subsequently reading them again while noting potential codes for passages in the margins. These preliminary codes were used to categorize the data and stayed close to the raw text. Certain codes also had the option of including a valence (+ or -) to identify whether the quote illustrated a situation that could be assessed as positive or negative The following examples illustrate brief excerpts from longer passages and their' associated codes: "the way me and [my cousin] grew up, we just like this- the best of buddies" coded as "Social network: family +"; "it was a lotta young kids doing stupid stuff, but, you know, it's like a lotta shopping areas, like supermarkets. It's kinda peaceful to me" coded as "Neighborhood Quality" & "Neighborhood Resources"; "I gotta pay the um, um, monthly metro is like $40, $52, so, my cell phone bill is $50. I know my whole budget!" coded as "Money"; and "I get up, take a shower, brush up and everything and go to work. If I am not working, I just stay home, watch movies, go to places to hang out, and that's about it" coded as "Daily activities" and "Work." Some final themes emerged fairly directly from a single code, such as the code and theme "Responding to Unwelcome Requests," while others were constructed by finding connections within and across codes such as analyzing connections between the codes "neighborhood quality" and "drugs".

This strategy of staying close to the raw text has several strengths for rigor in data analysis. An inductive approach can help to minimize the degree to which a coder projects or imposes *a priori* theories or ideas onto the data, thus potentially minimizing the degree to which codes are ascribed to data that do not reflect participants' statements but researcher biases. This was monitored further through a memoing process described below. The study also used multiple

coders (i.e., analytic triangulation), which is recommended as it minimizes projection by introducing a diversity of perspectives that can counterbalance individual coder biases (Boyatzis, 1998; Padgett, 2012). As noted, preliminary analyses which focused on open-coding were conducted by the author and a research assistant. During this process, we independently read and coded two transcripts at a time, met to review each transcript, and discussed which codes could be used, modified, or eliminated based on the frequency of occurrence and meaningfulness of chunks coded thus far. Because an inductive approach yields first-order codes that are close to the raw data, it generally increases the likelihood that coders will code information similarly, resulting in greater reliability (Boyatzis, 1998). These coding meetings continued until a final coding protocol was developed, which included descriptions and definitions of codes.

In step two, using the final coding protocol, the author and a research assistant separately reviewed and coded all transcripts line-by-line, discussed discrepancies, and attempted to resolve disagreements through consensus, but with the author having final say. Due to the complex challenges involved in calculating formal quantitative measures of reliability using line-by-line coding of semi-structured interviews, formal reliability scores were not calculated, but the method of using multiple coders within an inductive approach can increase the consistency with which codes are applied (Boyatzis, 1998; Padgett, 2012). To further increase rigor in preparation for the analysis stage, memos were kept during code development that constitute an audit trail documenting emerging theories, themes, interpretations, resolution of coding conflicts, or questions that will be followed up in the interpretation stage (Lincoln & Guba, 1985). Memos were also used to note excerpts that were particularly illuminating or illustrative.

The third stage of analysis required moving from the codes to higher levels of abstraction by analyzing and clustering codes. Codes were examined to determine whether there are

underlying concepts unifying certain codes, whether certain codes tend to overlap or frequently co-occur, and whether certain codes are subcategories of larger themes. Excerpts of coded text were re-read and analyzed to determine how codes may be similar or vary across instances or individuals and how they relate to larger themes. At this stage, codes and coded excerpts were also linked to individual research questions. Finally, the broader themes and concepts which emerged from the data were then linked back to existing research and theory.

This analysis relied heavily on grounded theory methodology - a highly inductive method of data analysis that guides the researcher to label, code, and organize chunks of qualitative data in a meaningful way that facilitate the detection of theoretical concepts from the data. While, in many ways, grounded theory requires a researcher to "suspend" relevant *a priori* knowledge so as not to bias data analysis, a *constructivist* approach to grounded theory recognizes that analysis cannot be conducted entirely in a theoretical or disciplinary vacuum (Charmaz, 2006). Preliminary study design and latter phases of analysis, in particular, cannot be entirely devoid of pre-existing theoretical concepts, because researchers seek to either develop study questions and procedures or link emerging findings to extant knowledge. The open-coding strategy utilized in this study takes the approach of first defining what "is happening in the data," and then applying sensitizing concepts such as symptoms, stigma, or poverty in latter phases when codes are linked to form themes and themes linked to form broader theories. These sensitizing concepts suggest constructs that may assist with interpreting data, but their use and applicability to the data is consistently challenged and re-evaluated (Bowen, 2006). As Charmaz (2006) notes, these "extant concepts [must] earn their way into [a] narrative" (p.166). The data analysis should reveal, therefore, whether these concepts enhance understanding of participants' social experiences.

CHAPTER FOUR:

Results

Appraisals of Social Connectedness

Factoring in the quality, frequency, and intimacy of involvement with friends, acquaintances, family, significant others, neighbors, casual community members, peers, and program staff, the vast majority of participants at both time-points (18 at baseline and 7 at follow-up) could be considered as having fairly low social connectedness. Participants in this category generally had no intimate friends and no relations or limited relations with family.

> The people I see on a regular basis is mostly from [the program], from Monday to Friday and after that I am just home alone, by myself, in my house…On the weekends, I stay home and write. I stay by myself…No friends, no girlfriends, no nothing, just by myself.

In terms of medium levels of social connectedness, 6 participants at baseline and 5 participants at follow-up were in this category. Participants who had medium social connectedness tended to have at least one close friend or family member with whom they had fairly regular contact, as well as a couple of other acquaintances.

> I am going to my brother's house next month… I'll probably go in May and spend it with my brother and his wife. I like his wife, I get free haircuts…I have a good relationship with all of my family…[Rudy[2] [peer from program] and I] We talk…I see him all the time…I don't have too many friends.

The few participants (2 at baseline and 2 at follow-up) who were fairly high on social connectedness had multiple close friends they could talk to, had other family members, friends, peers, or acquaintances with whom they had fairly regular contact and engaged in various social activities. The participant below exemplifies this level of social connectedness.

> The [women's] group is a couple of hours and then at least once or maybe in twice a month, we'll go out for dinner. We'll schmooze and hang out…And I will go to that [women's] group or meet with my friend Sandra…We meet either for a late brunch....um,

[2] All names and locations have been changed or redacted to maintain participant confidentiality.

> basically my socializing takes place with Jimmy, Imaan, Sandra, or if someone wants to come by and hang out a while…Um, Jimmy comes by a lot…normally when I go to his house, it'll be on a Friday… I'll go and I'll stay at his place until like Tuesday.

In general, women had much less involvement with family members and described family interactions in more negative terms. While men experienced negative family interactions as well, several male participants reported close and fulfilling relationships with family. None of the women, however, had consistent contact with family members at either time point.

Overall social connectedness was fairly low among participants across the sample. There also emerged a tension between participants being somewhat satisfied with their more solitary status, but also having the desire for more intimacy and interaction with potential important others. When reflecting on their more limited connectedness, many participants expressed an appreciation of the time they spent alone.

> Uh, [by] myself. Myself. I learn how to do that. I enjoy my own company. I used to hate it. And now, all of a sudden, things turn. Now I enjoy my- like I said, I enjoy my own company. I be sitting at home, have a beer or watching the TV, and I be, you know, watching the TV, and enjoy it.

> I'm kinda content. I'm an only child, ok? And I learned to appreciate my own company many years ago, even though I had a lotta animals. I learned to appreciate my own company. Yeah, so I have no issues of having to hang, and having someone to have to hang with me, and…No, I don't have that need.

At the same time, however, participants' statements indicated that they may not have been entirely content with their overall social connections, revealing an ambivalence that characterized many participants' views. The participants referenced above who enjoyed time by themselves also stated:

> Well, (pause) my biggest concern is loneliness. I am just tired of being alone so long. And that's really bothering me very much and [if] I just could figure, anyway, how, really to deal with it or to get out of it. I, like- I'm stuck, and that's really right now is an issue with me. And I'm working on it, but I still could find no solution.

> I realize that in the last couple of years that I miss the company of women, just a whole bunch of women hanging out… My mother always had friends who we went out to dinner with- girls. She raised me- my- so, I learned that it was positive to be around a lot of women…But I miss the company of women. When I'm around women- it, if you're not pursuing a relationship to a person, you're just wanting to be there, to be there… Women…the camaraderie, right. I miss women, I miss my mother.

While participants described themselves as people who appreciated being alone, their desires for close, meaningful relationships potentially belied their complacency with their status as "loners." When discussing what was missing in their lives, participants most commonly responded that a close other, sometimes simply a companion, but often a significant other was what was lacking:

> Cause I get bored in my house, and stressed out sometimes. I got my cat, but my cat can't talk to me, so…I'm like, I want a friend. I want somebody that I could talk to and stuff like that…

> I'd like to have a good woman in my life, finish school- somebody to support me and that I can talk to, other than the kids.

> I just want someone that could make me happy, make me laugh, knows how to show affection…I'm missing a partner that meets me 50-50, doesn't depend on nobody, has high self-esteem and loves themselves. Doesn't lie.

> I'll tell you the truth: what I need now is a good woman, a woman that I can trust. That's what I need in my life- and a job.

Someone capable of mutual giving, trust, and being a confidant were the key characteristics of the type of person that participants desired to have in their social network as a companion, friend, or significant other. In contrast, many of participants' previous social relationships were characterized by mistrust, betrayal, disappointment, and experiences of people taking advantage of them, making them more hesitant to pursue connectedness.

> I am kind of scared right now…Being hurt, being too close, being betrayed…. emotional pain. It could be mental, physical pain too, afraid of hurting myself or somebody else. So if I stay by myself, I feel safer.

Participants also mentioned children as missing in their lives. They expressed a desire for more contact and involvement with existing children and/or a desire to have children: "My daughter –

cause I had full custody. The mother could get her three days a week, but now I can only see my daughter when she [mother] feels like it until I go back to court…"

One participant summed up her ambivalence regarding social relationships stating: "I have to be a loner. I don't know anyone." Statements such as this suggested that this "loner" status did not necessarily reflect an inherent personality characteristic, but perhaps a more complex process beyond an explicit preference. When participants elaborated on their personal orientation towards a social life, their descriptions referenced relationships as a source of stress.

> Um, I guess I'm a private type of person. I'm not a hanging out type of person anymore, like I used to, you know…it's stress, you know…I just say good morning, how you doin', drink my coffee by the store, then I come back upstairs, and that's it. I'm tryna- less stress, you know. Cause the less I deal with people, the attitudes, and stuff like that, the less stress I deal with. Cause I was in the hospital for stress. I'm not tryna go back in. I was really stressed out. Lost everything.

Participants indicated that they purposefully limited connectedness, but their descriptions revealed that this distancing was often employed as a strategy for managing potential risk. In describing their daily routines, for example, participants noted that limiting social connectedness was intentionally used to avoid potentially challenging situations.

> [I] sit down and watch TV for a little bit and relax, go for some fresh air, and then go back in the house and relax, and try and stay away from trouble so much as possible. [Weekends,] sit and watch TV, sit down and relax. Stay in the house, stay to myself as much as possible…I can go into [the apartment] with keys, I don't have to worry about nobody in the apartment, live with somebody else…I'm glad of that…I can go in my house, closin' my door, turn the TV on, and close the world out...Only when inside, I feel better, cuz I don't hang out, so it's better for me.

Another participant had recently had a negative experience with two other clients while living in a house owned by the program. This stressful situation discouraged her from seeking social relationships either in her neighborhood or through the program.

> I used [to] live with [two] other women. I am just recovering from being in that house with those girls. I mean, can you imagine one of them took a new vacuum cleaner and threw it at the other girl? Breaking the door down… so what I am doing is getting my

> nerves together… [My new neighborhood,] it's a nice neighborhood…I feel comfortable, just don't have any associates. Like going to somebody's house for dinner. I don't have that and I probably don't need that right now…I was shaken up with the situation I was living in. I mean how can you associate with a person that yells and hollers all weekend. It's no good company… I don't really feel I need to meet people out here [at the program]. I mean, I need to get away from people.

One participant's description of his interactions with the outside world typified many responses across the sample: "I go out, I don't do nothing. I go out and mind my business, you know. I don't go looking for trouble. A long time ago, trouble used to come to me." Even participants who were relatively higher on connectedness were explicit about noting their cautious stance towards social connections, illustrating that distancing was not a strategy employed only by those who were isolated: *"*my fr—the few friends that I've allowed, or people that I've allowed to become my friend, um, have been very supportive." The concepts of purposefully limiting social connectedness as a means of staying "away from trouble," and viewing the home as a sanctuary will be recurring subjects underlying many of the thematic findings and are explored in-depth in the coming sections on factors that facilitate or hinder connectedness.

Change (or Lack Thereof) Over Time

Interviews of the subset of participants were examined for changes over time in social connectedness. Of the 12 participants who completed a follow-up interview, 2 had lower social connectedness compared to eight years ago, 3 had improved their levels of social connectedness, and 7 had stayed about the same. Analysis of these changes, or lack thereof, confirmed a continued focus on factors such as the risks associated with connectedness.

Examining the case of one participant, who experienced the most significant drop in social connectedness, illustrated how close involvement with others could potentially have negative consequences. At baseline, this participant had a boyfriend, socialized with a few

friends, had intermittent contact with extended family, went to church and AA meetings regularly, and periodically attended social events. Though she still felt lonely at times, her coping mechanisms revealed that she had an available support network to which she could turn.

> Um, sometimes I get lonely. Yeah. I look at- I've got four photo albums, I look over my pictures, um, I'll call Jenn [neighbor], um, I might call my auntie, um, I'll call Mr. Barnes from church, um, I'll try to escape in like a television show or a movie. And I've been reading some magazines…and I find them to be good, so I read.

Eight years later, however, almost all of these network members are no longer in her life and she is no longer participating in church or AA. While the participant was somewhat vague regarding how things had changed, she noted that the chain of events included difficulties with an intimate partner, relapse to substance use, compromised mental health, and difficulties with neighbors, which culminated in a move to a new apartment. During this time and after the move, she lost most of her social network and her coping methods for loneliness had changed. She no longer sought social support but played out imaginary social scenarios at home:

> And then I enjoy the most coming home to my apartment and listening to my music. Having to have my make-believe friends and watch television…Sometimes I be in [here] talking like, "Yeah, girl," like somebody really be in here.

Despite a professed contentment with being alone at home, she also expressed a desire for having someone close in her life.

> Missing in my life? How can I say it? Like, I wish I had a guy friend. I wish I had somebody, who don't have to live with me, but you know, could come by, keep my company. Somebody I can trust.

In keeping with findings emerging from overall appraisals of social connectedness, an ambivalence toward social connectedness emerged once again and involvement in problematic relationships, particularly with significant others, was highlighted in contributing to social isolation. Similarly, participants who experienced no changes, or minimal changes, continued to emphasize the problematic nature of connectedness.

One participant, who had medium levels of social connectedness at baseline, increasing to high at follow-up, continued to enjoy the company of his friends as well as going out socially. One of his stories of going out to a bar with a friend, however, also illustrated how this greater connectedness could indeed potentially expose a person to troublesome situations.

> My friend was all coked up…I said, "I gotta leave. I gotta go to work at 5:30. But you wanna stay? I don't wanna stay, man." Two beers, that's it...this girl came up to me, like, you know?...She said, "What's your name?"…but I saw she walked in wit' a guy! So I didn't wanna- I just walked away from- I said, no…When a girl walks in wit' a guy, the guy's sittin' down, talk to his friends, talk to the bartender…[She said] "Talk to me." I said, "No, no." I just-I just don't go for that. You know? And then the guy- the guy says, "What're you talking to that guy?" He starts smackin' her around, but I'm gonna pick up a pool stick- I pick up the, um, I pick up the bar chair and I smacked the guy in the face with the chair. I don't wanna see him hit a girl in a bar. And then the bartender kicked me out…

The possibility of scenarios such as this could be viewed as the type of situations that led participants to feel the need to distance themselves from others in order to "stay away from trouble."

Three participants experienced an increase in overall connectedness over time, though only one of them experienced changes that might be considered substantial. Changes were generally reflected in improvements in the quality of relationships, which then translated into more frequent interaction. All participants were men and experienced improved relationships with their families; two of them also had more frequent interaction with a few close friends and one of them also experienced improved relations with the mother of his children. Nevertheless, this greater connectedness still potentially carried a trade-off for at least one of these participants. At baseline, the participant had been concerned that his family was using him for money. At follow-up, while he did not indicate that this was explicitly still an issue, he did note that his brother, who did not have a place to live, had now moved in with him. Thus, while he experienced improved relations overall, it had come with the trade-off of once again being used

for a resource and potentially sacrificing the sanctity of his home. The potential consequences of this were particularly significant since this participant had remarked in that same interview that: "If I don't have a peace of mind at home, it could interfere with my daily living skills, my daily activities, and how I conduct myself with people on a everyday basis."

Another participant experiencing improvement had described himself as fairly isolated from his family at baseline, but also wishing they had a better relationship, citing family "drama" and a lack of reciprocity.

> And my family, they got a lot of drama in they life and I try to stay away from that…My aunt fighting with her sister. My cousins fighting with my sisters. And I ain't got no time for that. I don't have time for that. So I just stay away, man. I'll just stay away…I don't even get a phone call at my house. You know what I say? They got my number. I gotta always reach out to them. Why can't you reach out to me? And that's how it's always been…your own family can't even call you and be like, "I love you. How you doing?"

At follow-up, however, he described better relationships with his family as well as more interaction with them and other friends.

> My moms and my sisters- I got three sisters…I see 'em on the holidays more, cause I seen 'em Christmas, I seen 'em on Thanksgiving, I'd say like around the holidays… or somebody plan a sibling day. [My mother] she's into her grandkids, though. She proud of me, 'specially I take care of my ki[ds]—like regardless… I see my older sister more than I see everybody. Cause my older sister's in Brooklyn, and then when I go to see my kids, they in Brooklyn. At the end of the day, if I need somewhere to hang out with my kids, I go to my sister house, so my kids could see they cousins, and, she the closest in Brooklyn, so… Laura [is] a good person…we're friends… We talk a lot on the phone. It's certain things she do that no other woman do, like, if I need money, she the only one I know that'll send me money. So she'll come…and go to the supermarket, and then get [groceries] delivered to my house, spend a little time wit' me and then she'll go.

In addition to demonstrating changes in relationships, the quote above also speaks to the importance of being responsible for children and how they are tied to overall connectedness. This is related to a larger theme of "taking care of others" that was beneficial for participants' social connectedness. Table 4.1 summarizes the themes and subthemes related to social connectedness that emerged from the data and that are explored further.

Table 4.1 Themes and Subthemes Related to Social Connectedness

THEMES RELATED TO HINDERING CONNECTEDNESS		THEMES RELATED TO FACILITATING CONNECTEDNESS
Responding to Unwelcome Requests: Network members tapping into participants' resources • Evading Requests for Money • Being Used for Housing • Protecting Possessions		**Connecting with the Past**
Exposure to Illicit Activity • Avoiding Relapse Triggers & Safeguarding Recovery • Avoiding the Criminal Justice System • Avoiding Illicit Activity in the Neighborhood		**Taking Care of Others** • Caring for Aging Parents or Relatives • Carrying out Parenting Responsibilities
Limited Funds: Providing for Basic Necessities Limits Social Activities		**Pursuing Artistic/Creative Activities**
Contending with Stigma: The Intersection of Multiple Marginalized Identities (Associative Stigma and Denials of Personhood)		**Accessing Neighborhood Distal Supports**
Racial / Ethnic Contrasts: Avoiding Drawing Negative Attention • Lacking Fit in Neighborhood • Experiencing Racial Discrimination		**Accessing Neighborhood and Local Resources**
Women Experiencing Controlling & Abusive Relationships		**Having Employment and Volunteering**
The Effects of Aging • Maturation • Struggling with Health Issues • Network Members Passing Away		

Factors that Hindered Social Connectedness

Responding to Unwelcome Requests: Network members tapping into participants' resources. Since almost all participants relied on SSI as their main source of income, they had very few financial resources. Given that federal SSI payments were $597 per month in 2005 and $710 in 2013, with less than a $100 state supplement, almost all lived well below the poverty line. Likewise, network members were often in similar – or worse - social and economic circumstances as reflected not only by their limited incomes, but also by their lacking stable housing or employment. This often led to participants being targeted by network members for assistance. Participants were thus faced with dilemmas regarding how to manage these relationships; relationships which –while meaningful, important, or otherwise simply satisfying needs for companionship - also exposed them to stress and threatened their resources. Ultimately, these types of challenges led many participants to end these relationships and/or become wary of getting involved in new ones. One participant summarized the ways in which his now ex-girlfriend lacked resources and the factors that prompted him to break it off:

> "Why you have to come here? You ain't got no job, you stay with friends, and sometime you come to my house." 'This friend is botherin' me,' "you wanna spend the night with me…" all she have is food stamp…she told me she have psychiatric problem, but she's not qualified. She's not qualified for SSI. And uh, she only have food stamp, you know what I'm sayin', she don't have no SSI, no job… I told her, "You don't have no job, no nothin', why you comin' to me for?"

The following subthemes specify the many contexts in which these concerns played out and how, for many, these situations led to their deciding to end or limit their social involvements.

"They were using me for money": Evading requests for money. Participants often found themselves in difficult situations in which they had limited income, but felt compelled to honor requests for money from friends, acquaintances, or family members who were struggling financially. Experiencing these requests repeatedly, however, could become overbearing, leading

participants to avoid potential exposure to situations and people where this might happen. One participant said it was nice to sit in his new neighborhood where nobody knows him, as opposed to his old neighborhood of Brownsville, which he now visits only periodically, in part because of avoiding requests for money:

> In Brownsville, you can drink coffee, but you always have somebody that you know that bumps into you and bothers you…sometimes it's annoying, you know what I mean? I'm sitting in the club: "You got a dollar? Come on, gimme a dollar."

Some participants had realized their friendships were too often characterized by requests for money and so decided to remove themselves from these relationships, particularly when there was no sense of reciprocity.

> I cut a lot of my friends off. I cut a lot of them off. Cause it wasn't about anything. They were just money hungry. So I cut a lot of them off…I had these, so-called wanna-be friends, just wanna dig into your pockets…They take you down…when you needed something in return, [they] just couldn't do it. Always some story, some bullshit about it- excuse my language- and they said, no, and… You start to realize, well, if I look out for him, he can't look out for me, when I need something…then it's not worth it.

While some participants had ended relationships with "old friends," others found that these issues were pre-empting potential friendships with new acquaintances. One participant became friends with another Housing First client who was a neighbor in his building and gave him a picture frame as a gift. Soon, requests from the other client escalated:

> [He] asked me for $2 for a MetroCard. I gave it to him. He said he would give it back to me. Then, he asked me for $5 for an extension cord. I [was] like, "Oh my God, what did I do!"

Many participants felt that their only option was to stop interacting altogether with close others who asked them for money, feeling that maintaining contact simply posed too much stress: "I feel like I am being used like a dollar sign. For my family, everybody, they are using me for money. So I just keep my distance."

While most participants distanced themselves from others as a way to manage these requests by avoiding them, there were exceptions. One participant struggled with the fact that his brother was homeless and needed money, but was likely to spend the money on drugs or alcohol. The quote below illustrates how this participant set parameters around how he would continue to help his brother, which included not directly giving money but still providing financial support indirectly:

> He an alcoholic. Me, I don't give him no money for alcohol... I take him to McDonald's, I buy food for him. "Money – you isn't getting from me. If you want cigarettes, we will go to the store and get cigarettes..." I won't give him no more than $2 cause I know if I give him more, I know what he going to do with it.

Participants struggled with managing these unwelcome requests from individuals who were in similar strained financial circumstances and it was incumbent upon them to adopt a strategy for dealing with these requests. While some conceived ways to negotiate these social interactions on their own terms, these experiences often led participants to reduce or break off contact with family, friends, or significant others as their dominant strategy of managing the risk.

"They try to take over your apartment": Being Used for Housing. Akin to the ways in which participants and their network members were in similar financial circumstances, participants' involvement with individuals who were experiencing housing instability also posed challenges. Participants reported difficult situations with which they had to contend as well as a complex web of relationships in which their partners were involved as a result of couch surfing. In addition to the potential emotional consequences of such entanglements, participants would often be called upon to provide assistance with housing. A participant described such a scenario with a boyfriend, whom she met through an NA meeting:

> He [boyfriend] needs help, he gotta find him a job, he was working, but he got fired…He even asked me the other day, he said, "Can you, can you get me with [the Housing First program]?" I said "I don't know." (laughs). He's homeless. He's staying at his cousin

> Eric's. Um, he was married, um him and his wife they just friends now, they have four children together. His wife has, you know, a lover. And uh, sometimes he'll crash there, sometimes he'll stay with me.

Another participant discussed her multi-year, on-off relationship with her boyfriend who was homeless. His homelessness made it difficult for them to keep in touch, which was stressful for the participant, and once again created a situation in which the participant was expected to assist with housing.

> He just stays in abandon cars, abandon buildings…I try to get him in with [the Housing First program], but he don't want to be with [it]. He'd rather be with me…I feel that I ask [his mother] "Mommy, where's John?" and mommy don't even know. Because sometimes John will leave and he don't tell nobody where he's going. He'll go for the whole night, all next day without calling nobody…

Because relationships, particularly with significant others, had sometimes become intertwined with a dependence on resources, it meant that many participants – back when they were homeless or had difficulties finding a place to live - had engaged in relationships that were not necessarily positive in other ways.

> We only got together for financial reasons…just to have an apartment. Yeah, we stayed together for seven years, but it wasn't a good relationship, you know? We didn't really get to know each other, and stuff, we just agreed on getting an apartment together, you know, and that was it.

Participants' own experiences of having been in need of housing and dependent on others may have led to not only maintaining potentially negative relationships, but it also may have made participants feel more compelled to share their housing with others who were now in need. However, the greatest danger that emerged was that sharing their apartment with someone could ultimately jeopardize what many participants considered one of their top priorities – their housing and stability.

> Number one, I don't wanna lose my apartment. That's why I'm not—I don't wanna do no drugs. And I don't bring certain people in my apartment. You know what I'm saying? Some people, will be in and out of apartment, they try to take over the apartment, you

> know, I don't want that to happen. One time I had that problem. A girl - I was goin' out wit' her - and she tried to take over my apartment…I had a fight with her, right, and I called the police. I told the police, "That woman is botherin' me. She was on drugs, she tried to take over my apartment. Can you please talk to her?"...And they made her leave, and she leave.

Another participant struggled with not wanting to be alone and so invited someone to stay with her, quickly exposing herself and her housing to negative consequences, including an eviction. By discussing the trail of guests which ensued, she demonstrates just how endemic the problem of housing instability can be among network members and those members' own networks.

> They gave me my own apartment at 144th Street. But I always felt like I couldn't be alone, so I started bringing this guy in. And this guy started bringing his cousin in, and his cousin started bringing his other cousin in, and everybody was living in the house.

This history of exposing their housing to risk as a result of involvement with others who were in need of housing, and often using alcohol or drugs, could subsequently make participants – at the very least - attempt to impose limits on interactions with network members to try and safeguard their housing.

> I got kicked outta there [my old apartment], cause of my company…They were night people- come over to drink and stuff like that, and sometimes I'd be sleeping and they wanna hang out, and I'm like, "No!" So I disconnected my bell. They started ringing other people's bells. So I got in trouble. So I got kicked out of there…but I don't let them [neighborhood friends] come to my [new] house that much. I don't tell them to come, I don't invite them, but they come ring my bell. Sometimes I don't answer the door and they just keep ringing the bell, and I be like, "Shh." That shit gets on my nerves.

In the extreme, previous negative experiences could also make participants wary in general about actively pursuing future relationships.

> If I meet the right woman, I won't mind. But I don't go out with any woman right now, because they give you problem! They try to take over your house! You know what I'm sayin', they try to take over your house, try to take all your money, give you—take over your house!

"this is all I have…he will rob me": Protecting Possessions. Beyond being confronted with the threat of network members using them for housing, participants had other reasons for

drawing boundaries around potential visitors to their apartments, generally stemming from suspicions that network members would steal participants' belongings or otherwise mistreat their apartments: "See, there's a difference between friends and associates. I got associates in the community. Not friends…[we] talk, conversate, in the area…That's about it. I don't let 'em in the house…I'm more of a homebody."

While this participant ends his statement by labeling himself a homebody, his distinction between friends and associates indicates that the issue may also reflect a lack of a certain level of trust (to which he alludes later) in some members of his limited social network. Another participant goes further to explain why she is reluctant to invite individuals to her home out of fear of having her belongings stolen, particularly since she has very few possessions to begin with: "No [I don't have people over]…I don't want someone stealin' something from me. I don't got nothing." Similarly, the participant whose brother was homeless had to discourage the brother from staying or visiting him in his apartment: "He is older than me, but I don't trust him in my house. I know he is my brother, but this is all I have and if he robbed my sister, he will rob me."

One participant explained how all her relationships had been with men who had never had their own housing and, consequently, they could not be trusted to be responsible in her apartment. She had questioned whether one of these relationships was even worthy of having and subsequently ended it:

> He didn't do nuttin' for his self, neither. He was, like, kinda homeless, but livin' with his mother. All the men that I been wit', except Ron, live with some family member. They never had they own. So why bring 'em to my house- they wouldn't know how to treat my place. So I had to think about that before it got too far into the relationship, so I left that shit alone. I left that alone.

While some participants chose to try and not have visitors at all, others who learned from these past experiences now reported being very careful and deliberate regarding who they invite into their home: "If I invite somebody over, I like to invite people I come close to. I won't invite people that are around me cause they are around me- I choose my friends."

Having individuals over to one's home is generally considered a fairly basic component of friendship and social interaction. However, for these participants, even this fundamental and low-threshold level of interaction was viewed as a potentially risky situation, exposing participants to possible theft or damage to their belongings or apartment. In order to protect their possessions and tenure, they often chose to limit social interactions and set boundaries around visitors in their homes, trading greater connectedness and increased intimacy of those relationships for the peace of mind of safeguarding their belongings.

Exposure to illicit activity. The potential for becoming involved in illicit activity through social interaction played a critical role in limiting participants' social integration. Participants described their social worlds as networks and places that were associated with illicit activity, usually substance abuse and drug selling. The composition of participants' prior social networks, their own past experiences with the criminal justice system, and the conditions they perceived in their neighborhoods influenced participants' decisions to curtail social connectedness and, once again, triggered avoidance of social interaction as a strategy for safeguarding well-being; in this case, to safeguard recovery and keep their freedom.

Avoiding relapse triggers and safeguarding recovery. When discussing their current social relationships, participants often attributed their lack of social companionship to their having severed ties with networks members who were still using substances. Participants stated that removing themselves from these associations was a key component of safeguarding their

recovery from substance use and maintaining the positive strides they had made: "All of my past relationship was while I was active…now I have to cut them loose for me to get better." Participants noted that much of their social network had previously consisted of individuals who, like themselves, had experiences with substance abuse: "I don't have a friend like that. I had, but they smoke pot…[most of them] had a substance abuse history." While most participants reported having already ended such relationships, a few were still actively struggling with the dilemma of connectedness: participants had to weigh losing social relationships, but protecting recovery, with preserving relationships, but sacrificing other areas of life that were important to them, such as work.

> My decision that I'm trying to make right now is to stay away from my ex-boyfriend. So I could keep my job because I used to drink every day, every day, every day wit' him. Every day woke up drinkin'. And I had to go to work, so he was not good for me at all. I went to sleep drinkin', I woke up drinkin'.

Decisions to end these relationships were particularly significant in shaping participants' potential for social isolation since the use of alcohol or drugs had characterized so much of their social networks (cf. Alverson, Alverson, & Drake, 2001). Consequently, participants found that when they severed ties with other people who use, they lost the majority, if not all of their friends.

> No, I ended- I don't hang out with certain people like that no more. I ended, I ended that friendship. I don't wanna be botherin' with those people no more because they try to make me smoke weed, stuff like that, even all this stuff, and uh, drinkin' so much, I don't wanna hang out with them. So what I do is, after work, I go home, watch TV. That's what I do- do that a lot. Watch TV…That's the reason why I be by myself a lot of the time. Yeah, that's the reason why.

Another participant echoed the isolation that resulted from his cutting ties with others who were using drugs or drinking alcohol:

> I have ended relationships with some of my friends intentionally because they are doing things. They are getting high, smoking pot, drinking beer, and I don't do those things

> anymore. So I have to put up bridges between me and those friends. So, my friends are my cats.

While most participants were comfortable with their decision to cut ties from other users, they still expressed a desire for involvement with "positive people." However, opportunities for developing positive relationships appeared to be limited, thus sustaining their limited connectedness. For these participants, many of whom had been through multiple substance use treatment programs including AA/NA over the course of their lives, there was difficulty attaching to these traditional "recovery/sober" communities. This is explained by a participant who weighed the pros and cons of attending self-help groups:

> Sometimes [it's good] because they can identify with me and I can identify with them. And it is also a good way to pick up again, trying to reminisce, start talking about what you did, and before you know it, you are hanging out. And before you know it, you are picking up with that person. So I don't think I am better than the next addict. I just don't like to be around a lot of people who have issues like in NA meetings…for some reason, I am the kind of person that if I go to any meeting, the first person that I latch on is that one that is probably getting high...It's hard in regards to my recovery. It does the opposite so it's hard for me to go to meetings…

Further, AA/NA may not have been a good fit for those individuals who did not equate recovery with complete abstinence from all substances. Some participants acknowledged drinking alcohol periodically, but emphasized that they no longer drink excessively, "like I used to." Others also acknowledged periodic use of marijuana, but as illustrated by the quote below, they distinguished between "hard drugs" and "pot".

> I haven't did drugs, I haven't did hard drugs in seven years. The last time I smoked weed was about maybe- two weeks ago. I smoked one joint. But I mean, hard drugs? I haven't did hard drugs in years.

This in-between, informal harm reduction approach to substance use may have thus made it difficult for participants to embed themselves in the readily available networks in their lives: they no longer fit into their former networks of "hard" users who could jeopardize their positive

achievements, but they also did not quite fit within recovery communities that embraced abstinence from all substances.

While many participants had lost almost all of their friends and acquaintances when they cut off ties that were associated with substance use, a few maintained friendships with network members who, like them, had at some point given up problematic substance use. These friendships could provide meaningful social interaction and support to participants, but others potentially perceived such on-going friendship with a former user as still characterized by substance use.

> And when people see me and Tony together- right away, the tops of their heads: drugs. Right away: drugs. Cause they know he's a druggie- ex-druggie, I'm a ex-druggie. So they see me and him together, right away, "Oh, they going to get drugs." But maybe we're goin' to get espresso at Dunkin Donuts…like, right away, my sister…"Oh I heard that Tony doin' bad now"…we stopped doin' drugs. We're better, you know what I mean?

Even for the few participants who had made new acquaintances or friendships, attempts to avoid relapse triggers could still make it difficult to socialize with the few individuals that were in their network. This is illustrated in the following scenario where a participant was enjoying herself at a party hosted by an acquaintance from church, but then had to leave once alcohol was being served:

> And this lady named Rhonda, she gives a party the day after Thanksgiving, on a Friday. I went there, and, it was cool. I was dancing, and it was nice. And then all of a sudden I started seeing vodka and stuff, because some people- they- some people not in the AA, they just come to the party. And I was like oh, boy. (laughs) I said, I've got to go.

Avoiding the criminal justice system. Similar to avoiding people and situations that could expose them to substance use, participants were also keen to avoid circumstances that might expose them to police intervention. Because participants had been homeless, had mental illness, and histories of substance abuse, they tended to have a cluster of factors that exposed

them to greater risk of attention by the police. Most participants had some prior contact with the criminal justice system and so staying out of jail/prison was a priority.

> Some of us got more ground, some go to jail for stupid mistakes - believe me, nothing really criminal…That is one of my priorities: not going to prison. I mean, I have been to jail and that is really drastic. I cherish my freedom like nothing else.

Another participant – though not sharing the specific circumstances – reported a recent court settlement from having recently been "locked up, for [being] wrongly accused."

These past experiences with incarceration made being "at the wrong place at the wrong time" a particularly salient concern that made participants cautious in their associations and movements. This was most explicitly manifest in those who reported keeping their distance from individuals who, like them, had histories of mental illness, alcohol and drug use, or interactions with the criminal justice system, believing that such associations could potentially expose them to troublesome situations. One participant, who was currently on parole, while buying lunch with a fellow peer, was almost dragged into a fight on the street by his friend, and had to convince police that he had not been involved in the conflict. He succinctly emphasized his decision to avoid certain people: "Some of them act stupid on the street, and I don't want to get in trouble." Another participant expressed a similar sentiment: "Actually, I'd rather keep my distance. It's better for me…That way I don't wanna get in the courts for nothin' I never did. Let me just avoid all that drama." Finally, all of the participants concerned with potential encounters with the criminal justice system were African-American or Hispanic, which is important to note given the disproportionately higher rates at which persons from these groups are potentially targeted by police and incarcerated (Mauer & King, 2007).

Avoiding Illicit Activity in their Neighborhoods. When participants were asked about what their neighborhood social activity is like, the most common response included some version

of the phrase "I mind my own business." Similar to how participants described many individuals in their former social networks as persons who have had some involvement in illicit activity or "trouble" (e.g., fights), they noted this was also an issue in the neighborhoods in which they lived. One participant's comment was indicative of a common perspective: "How well do I know my neighborhood? Enough to stay out of trouble." Though participants generally described their neighborhoods in positive terms, such as "quiet," "nice," and "they got everything," they also frequently noted the visible presence of individuals who were engaged in illicit activities. The sale of drugs was often the primary complaint and participants explained that this made them reluctant to "hang out" in their neighborhood. In the same way as some cut ties with former friends who were still abusing substances, participants generally avoided those hanging out on the streets in their neighborhoods in order to avoid being pressured into using or experiencing potential arrest or victimization.

> I don't like to hang out on the street. But you know, like, if you go on the corner you gonna see drug dealer, and stuff like that, but I don't wanna be involved with these people. You know what I'm sayin': certain people I don't wanna be involved with. They got drug dealers, you know what I'm sayin'. I know who they are, because I can see that on the street. I know drug dealer, you know… Try to make you buy drugs, I don't wanna be involved with these people, because I'm tryna stay away from drugs…

While drug dealing was the most frequently cited problem, one participant aptly summarized the perspective of much of the sample when it came to describing the negative presence of certain groups in their neighborhoods. The participant connected these groups to a host of problematic or illicit activities and emphasized that it stymied his desire to develop social connections or engage in social interaction.

> Well I'm looking for more positive people to reach out to. So far, on the outside, on the outskirts of my building, I see negative people, so I'm not ready. I'm not thinking about reaching out to them, cause they're negative. You know, they drug- they selling drugs, I'm pretty much sure they got tons of arrests on the rap sheet, cause those are the people ain't really follow what I did, you know- got help. So they rather disrespect they parents,

> uh, have apathy, they don't care about anything. You know, only thing they care about is money, sex, fights, or either trying to hurt someone. So that's more deviated from themselves….Yeah, so I wouldn't connect with them. Cause I learn from experience.

Others noted that concerns for their safety in general discouraged them from engaging in social interaction and led them to isolate in order to avoid possible victimization: "I feel by myself, I don't talk to nobody…Yeah, I don't see nothing. You never know what they might be carrying in their pockets and I'm not down with that." Another participant found this to be a particularly significant factor in causing isolation: "I'm not motivated to go out. Days go by and I realize I haven't left my apartment. Why go out there? Why do it, when there's nothing out there, except trouble?"

While participants noted the presence of illicit activity in the neighborhood and a desire to avoid it, the presence of such activity was commonly perceived as a given in the city: "Because in every neighborhood or every borough, whatever, there is always a situation going on, you know. And you can't get away with that, you can't get away from it now."

> Wherever you go, there is going to be drugs. There is nothing in the world that's going to stop the drug flowing. It may slow down, but they are never going to stop it, and I hate to say this, but in reality it's not meant to be solved.

For some, the view that illicit activity, such as the sale of drugs, was fairly ubiquitous was potentially influenced by the finding that it was something that they had encountered for much of their life.

> I use to live out there, but isn't nothing out there but drug dealers. I use to live out [t]here with my mother…You have to take the train far to buy something. You know, I have to ride the bus, but marijuana is convenient for me. That shit is like this: I could go right in my building you know, in the last floor, is convenient for me. And if the phone is busy, I write a little note and slide it under the door and I just wait there for 15 minutes. They come down and give it to me.

They also indicated that such things were generally to be expected in what they sometimes referred to as "ghetto" neighborhoods.

> [It's] peaceful. You know, what you see in the neighborhood is what you see- what you see in the ghetto: guy hanging in the corner. You know what they doing, [I'm] not getting involved with them. Hello and goodbye. "Want a beer?" and that kind of stuff. But I live in a nice neighborhood…three or four guys at the most hanging in the corner doing their thing…I got arrested twice for a $3 bottle of crack and for a $5 bottle of crack. I had to spend the night in jail.

Describing a neighborhood as a "ghetto" appeared to be tied to participants' perceptions of concentrations of poverty in an area. The ready availability of drugs was thus connected to living in what they surmised to be low-income neighborhoods: "I think it's mostly working class, but also poverty because if we were good, there would be no drugs and everyone would be happy…You can get any kind of drug." Another participant expressed a similar sentiment:

> You just see the paraphernalia lying in your hallway, or on the street corner... at each corner, there's a little cluster of boys, and sometimes with their girlfriends, you know, they're selling drugs. That's what they're doing. Even if you talk to them, it's like, very normal for them to do that…they don't enforce the quality of life up here, because it's a low rent district or whatever...

While participants tolerated detrimental living conditions in their neighborhoods—sometimes stating that they had grown up in areas with illicit drug traffic, or that such things were to be expected in low-income urban neighborhoods—they nevertheless made special efforts to avoid certain people and areas in order to make sure not to get involved with those "hanging out" on the streets.

> I bypassed [the dealin']. Like, over here, when I leave, I go the back way. I don't go the front way cause it's all drugs there. I mean, over there's a drug supermarket. So I walk this way…cause every time I walk there- I don't know, they say, we got methadone, we got cigarettes on sale, we got methadone, I don't wanna hear that. See, I focus on other things. Yeah, I always walk this way. I don't walk that way.

> That's like considered 'red zone' area. No cops around there. There's a bunch of crap going on over there. But I deal with it. I stay in my house when I'm over there. I go to the store on the corner... When it comes to walking up the hill, to the train, I don't do it. I walk three blocks down before I go up to the train station.

Once more, participants expressed preferences for staying at home or actively evaded segments of their neighborhood, feeling that certain places and people had to be avoided because they were perceived as associated with negative activities.

Limited Funds: Providing for Basic Necessities Limits Social Activities. As noted, most participants relied primarily on SSI for income, which equated to just under $800 a month in 2013. This translated into participants generally having extremely limited funds that they had to budget carefully and that left little room for discretionary spending. One participant explained this type of financial situation in detail, highlighting how most of his money was allocated to basic necessities, leaving little room for other personal spending.

> And, sometimes, I don't really have money for myself. Honestly. Sometimes I don't have money for myself…Sometimes I can't pay my rent. (Raising voice) Cause after I pay my rent, my [utilities], give my kids' mother money for child support, pay my cell phone bill, make sure my dog got food, buy my toiletries, buy the wash and cook—Yo, I don't have no more fuckin' money to—So, I stop payin' rent to keep a little extra money…

As illustrated above, very limited incomes meant potentially having to consider trade-offs such as not paying rent (and thus risking housing stability) in order to have some money for non-essential spending on oneself. These financial challenges put into play the strategic management of contact cited above and limited participants' connectedness in numerous ways. For example, it limited the potential frequency with which participants interacted with others, especially family, who were living in geographically distant areas: "I want to see my uncle in [the Caribbean]. I can't afford it. I can't afford to go as much as I would like to…" Beyond restricting the ability of participants to take trips to visit social network members in person, limited finances could constrain participants' ability to pay for long distance calls (especially before cell phones were ubiquitous).

> I'd like to see my Aunt more often, but she lives all the way out there [in another state]. It's sort of difficult…it costs- the Metrocard cost $5 or $6 and sometimes I don't have the

> money for it. Um, I talk to her on the telephone…but I haven't called her that much because it costs so much.

Beyond adversely affecting participants' ability to engage in consistent interaction and thus maintain current relationships, limited finances also hindered participants' ability to develop greater social integration and the requisite potential contacts for new relationships. One participant discussed how not having money made it difficult to attract a partner.

> I wish I could get married, find a nice woman, but nobody want me…I am a fifty-year-old man, single, and they don't want me. I not rich, I can't buy a diamond ring or a mink coat. They don't want me.

Beyond purchasing material things, money can facilitate day-to-day interactions and involvement in various activities, hobbies, or communities. For participants living in poverty, however, the lack of funds made it difficult to pursue leisure activities or cultural events, thus reducing their likelihood of spending time around other people:

> [I miss] going out more…I would love to go out on the weekends. I ain't got the money. Like this movie called Flight, with Denzel Washington, when that came out, I would have loved to go see it, but I ain't have the money. I would love to go see that play, Les Miserables. I would love to go see that. I would love to go see Lion King. (Laughs) I would love to go to Hawaii or the Caribbean Islands. I would love to do that, oh my…Like I said, I would like to go see a play, then come out, and go to like, [unclear] and have a nice dinner.

> It's boring and there's nothing to do. I would pick up the newspaper and see what's on and go see a movie. I mean, I can go on my own for ten bucks, you know, and if you really have to budget your money. I feel bad- like, right now, I getting $200, $300 a month and I have to buy food and clothes and pay my bills, so I really got to think what I am going to buy for food- you know, the luxuries – like eating out, you are eating out in a fast food place.

One participant clearly articulated this link, describing how not being able to engage in certain activities meant missing out on opportunities to meet new people and potentially expand one's social network:

> Libraries, and places where people meet. Cafeteria, coffee shops - where people gather and talk about things, issues, and stuff like that. That costs money! A cup of coffee may

> be $2. And, you know where is the place? Starbucks. Where people gather, with the commuters, and they get to know somebody and introduce yourself, then you know, that's the places where you find people willing to talk. About sensitive- about value things…And that's make it a little bit difficult. Because you cannot go these places and just sit down, talk. You have to order something. And if you stay longer, you got to order more. That's hard…Money, mother of all evil.

When asked about the things he does, or places he visits outside his neighborhood, this participant explained:

> Well, um, not much, because the main reason is financially. I, and people like me, we stressed. We live on a limited income, and barely enough to take care of the necessity. Forget privilege. We don't have no privilege. Unless we get chances and opportunity through programs, we get free tickets or some like that. So we get chance to go to movie or outing. But on my own, I just can't afford it. I can't afford $30 for a movie, or $30 if I choose- if I want to go out, I wanna have a nice dinner, I just can't afford to do that. Even though sometimes I do it. I do it, but when I do those things, I have to take some out of my daily living.

Once again, the difficult trade-off involved in setting aside money from basic necessities to engage in certain activities is emphasized. His explanation is continued below and further highlights yet another way in which lack of finances can fundamentally hinder social connectedness by limiting activities. Here, partaking in a restaurant meal, a fairly low threshold quotidian activity, enabled the participant to feel a semblance of normalcy despite his psychiatric disability.

> Well, I like to go out, have dinner. Have a glass of wine. At a nice place. I don't care what it cost. And I get fulfillment, enjoyment out of that. I mean, I feel for that hour or two hours, sometimes three hours, I don't care what they say…It feel like you become so-called normal, you get the taste of normal society. And that lifts me up. And want me to do- want to try to become more of one of those so-called normal society. I'm sick, and I get sick sometimes, real sick, but that's also don't have to stop me. So, like they say, if there is a will, there is a way.

Another participant described a similar sentiment when she treated a fellow client, with whom she was good friends and who also has a limited income, to dinner:

> And of course money is the issue. So when I'm flush- like, the last time I was flush for Bernard's birthday, we went out, had a nice dinner…and um, he was very happy. He liked going out. He felt more human, you know?

However, as noted, it was largely through sacrificing funds for daily living that participants were able to accomplish this; thus, achieving a sense of normalcy came at the expense of risking basic needs. Altogether, low incomes affect individuals' ability to participate in common life activities, directly hindering social integration. When they prevent participants from feeling as if they can engage in "normal" activities that reinforce personhood, limited incomes can also have an indirect effect by damaging one's identity, exacerbating the potential for continued social isolation.

Contending with Stigma: The Intersection of Multiple Marginalized Identities, Associative Stigma, and Denials of Personhood. In keeping with much of the literature on psychiatric disability and social isolation, participants in this sample identified stigma with respect to mental illness as a challenge to social connectedness. Beyond negatively impacting individual relationships, stigma was also identified as fundamentally hindering an overall sense of belonging and acceptance in the world.

> I had all this time to focus on who I was, to where I know who I am to a T. But I don't know how to…I don't feel that the world will accept me. I don't feel they accept me…I mean, it's not only me. It's just period. It's just period. Cause there's still stigma goin' around wit' people with mental illness, ok? Even if they don't treat me like that, even if it's, you know, somebody else. And people do got feelin's.

This stigma was perceived as partially rooted in, and sustained by, the media's portrayal of persons with mental illness as dangerous individuals who engage in violent behavior: "people in this world are scared of [people with mental illness]…because of the things that go on in the media: pushing people into the train, attacking people with bricks, raping them."

Beyond these previously well-established findings, however, participants also commented on how psychiatric disability intersected with several other factors that contributed to the stigma. For example, community members might associate a participant's having a psychiatric disability with a lack of the markers of "responsible" citizens, such as employment. Participants might be judged negatively, therefore, based on their unemployed (or underemployed) status or their receipt of government benefits.

> Some of [the neighbors] are nice people, they don't think they better than you. Some of them think they are better than you because you have psychiatric problems, you don't have a job – a good job – and some are just scared, you know how it is, just because you receive SSI.

In such cases, lack of participation in the labor market and receiving disability benefits appeared to be more influential in fueling the stigma than the mental illness in and of itself.

In addition to income and employment, race and gender were other factors that participants believed could affect other people's perceptions of mental health issues. For example, one participant, who was an African-American male, described how he believed that there was over-reliance on medication within the mental health treatment system for young African-American men, highlighting the disparity in treatment received by his son compared to his daughter.

> Let me tell you how society and system has built the fellas, ok? Now I been on medication since I was a kid, alright? Whatever issues, whatever. Maybe somethin' was wrong with me. Life always repeats itself. Why? My son has the same diagnosis as me: ADHD, mental depression. Okay, my daughter has a anger issue. Ok? My daughter's not on- they don't feel my daughter's on medication, but they got my son on medication. That's backwards. But at the end of the day, how did he get on medication? Oh, because he can't keep still. So that don't mean he's on medication and he needs it! The system gotta stop pushin' medication on all our young youths, because they a little wild. They need more groups, you know?

Participants also noted a host of other identities that could trigger stigmatizing attitudes and further exacerbate the potential for challenging social interactions. One participant summed up

the cluster of characteristics that she felt impacted her social world, illustrating how the intersection of multiple marginalized identities made issues of stigma particularly complex: *"*It's very bad [having a mental illness]. Because it's not bad enough about being queer, middle-aged, biracial Black, a woman…" Further description of these multiple stigmas was given by another participant who believed he was receiving differential treatment by his super. This participant attributed the super's dismissive behavior to negative perceptions of the participant's having a mental illness, to being of a non-majority ethnicity in that neighborhood, and to being gay.

> My radiator- a week into December- steam was just shooting out of it, and I called [the super] and he wouldn't answer the phone. I left messages and he didn't get back to me. I saw him on the street…and I said…"there's steam in my apartment from the radiator"… He went into the basement and didn't come up…two days before [Christmas] he comes up, and [by] now the ceiling is falling down, there's water dripping off of everything, um, and he could've cared less about it. And he came, two days before, did what he had to do, and fixed the radiator. You know, things like that, in the community would be good [to change]. I guess they have- you know, I mean, he goes into the Latin people's apartments and he fixes stuff, but for me, I'm this crazy person from [Program], and obviously he doesn't like some of the things he sees when he comes in here, and…So, so I'm not a priority and I'm not a consideration, unless I really press it.

Beyond potentially resulting in differential treatment in various life domains, stigma hindered social connectedness in multiple ways. As hypothesized by stigma researchers, the onset of mental illness could result in social network members severing ties with participants (Link & Phelan, 2001): *"*It's just that when I-I lost my people and I lost my home, I couldn't-when I had the breakdown, I lost a lot of friends. They didn't understand, you know…" In addition to losing network members, participants might also become keen on limiting social interactions with community members to avoid the potential of encountering mental illness stigma. In these cases, negative perceptions of psychiatric disability made participants feel more vulnerable to manipulation or victimization by non-peers, which triggered a tendency to distance themselves.

> Sometimes when a person is not mentally ill and they find out there is something wrong, they take advantage. Sometimes they think the word "crazy" means you don't have no sense – you don't know what you are doing and they try to play tricks on you. They figure that you are crazy and you don't know.

While some participants avoided general community members, others expressed the opposite inclination - a desire to avoid individuals who were also diagnosed with a psychiatric disability (i.e., peers) in order to avoid triggering stigma by virtue of their associations.

> I, personally, I don't like to draw attention cause that bother me more. I don't want to be labeled. And always people look and when they see a bunch of clients they already know, I think they already know, that there is something wrong there.

Thus, being among a group of persons who have psychiatric disabilities could make participants feel more vulnerable to others picking up on markers of mental illness. As before, this "associative" stigma (Mehta & Farina, 1998) or "courtesy" stigma (Goffman, 1963) could also extend to other challenging issues, such as substance abuse or criminal behavior.

> Yeah, but every time they see me with Jimmy, they see me with Paula, Ron, Paula- right away drugs. But you can't- see, the way people think in that neighborhood, they see you with a druggie, right away you doin' drugs with them…Come on, you don't judge people like that. Yeah, it's like, they're cold, like…I don't trust people like that.

In such cases, maintaining relationships with people who had been involved in illicit activity, such as drug use, could result in participants being labeled with a negative identity by virtue of their association. In turn, this could stymie their ability to expand their social connections.

Beyond affecting social relationships, stigma from mental illness was also perceived as a barrier to pursuing broader social roles, such as through employment or volunteering.

> I can't do that right now cause I have this mental illness. I can't go and volunteer because people are not wanting people that are crazy to take care of their [kids]…[In the past,] I was helping out children that maybe had no eyes, no arms or legs, I was taking care of them, so I did a lot of that and that's how I volunteered… I mean, you could never live your life the way you used to. And if you don't tell them [you have a mental illness] and they find out about it, it's worst. And if they know about it, they are not going to want you coming around.

Stigma could thus lead to a loss of prior roles and social networks, as well as exclusion from mainstream social spheres. Beyond this, however, it could also manifest as an assault on basic personhood and sense of agency. The validity of participants' perspectives and statements could be consistently questioned, potentially culminating in the need for every claim to be recognized and validated, usually by non-disabled others, in order to be viewed as legitimate.

> The thing is that, that um, living with a mental illness, coming to terms with the fact that you're mentally ill, knowing what that means, along with the stigma, how the acceptance you get, how you have to have someone to substantiate your position take or any claim you make. Always having to know that whatever you say to an individual somewhere, it's going to be weighted against the knowledge that you're mentally ill. Is this part of psychosis scenario? Or is this legitimate? So you find yourself living a life, but, that you have to substantiate.

While participants struggled with issues of stigma, living as a tenant in a regular apartment building allowed some participants to, at minimum, "pass" as any other community member (Goffman, 1963): "I don't think they know I got a disability. They friendly. When I'm not around, my neighbor looks out for my place." To some degree, being a community member and neighbor, and having the identity and responsibility of being a tenant, could also facilitate participants' ability to reclaim the legitimacy of personhood.

> I'm just an ordinary person, and, I mean, I keep my apartment nice and clean. And um, I guess I'm just an ordinary person. I mean, I have a mental disability, but I'm an ordinary person. I'm a good person.

Despite the ways in which stigma could undermine attempts at broader social integration and a sense of self, some participants had developed self-confidence over time and learned to avoid having to adapt (and potentially lose) themselves to a potentially challenging environment.

> If I am talking to myself, so be it. If I am still a little jumpy or shaky, so be it. People have to respect that. I am not going to change and live off the people's expectations. I am not going to do that. I got lost that way, I got twisted, my mind is all twisted…[In my building,] I feel that I can be myself.

This participant talked about how living in his building may have facilitated an identity as a regular, respectful tenant as he assimilated to the norm.

> The [building] is pretty cool. Everybody respects each other and that's the way it is. I mean, my subconscious might have picked up the environment, atmosphere, and I follow what they do, and I not aware of it, but I am starting to be aware. I've been living here for a long time, four years.

For this participant in particular, combating stigma had also become a motivating factor to grow and develop in positive ways.

> Some people have passion at smoking crack, some people have smashin', passion doing drugs, or going to jail. I don't have passion for that. I have passions to learn. So I could keep myself from those negative elements. The more knowledge I have, the more I'm sane. The more I'm stable, the more I function. Outta hospitals, staying outta hospitals. Enjoying my freedom, not abusing my freedom, respecting others. So people could say, "You know what, not all people with mental illness is not what they 'pear to be- pushing people in train tracks, hurting people, even, you got people with mental illness is labeled as pedophile, perverts, and all."

Similarly, another participant was motivated to write and produce a play in hopes that it would mitigate the stigma of both homelessness and psychiatric disability.

> It's going to be a play about mental health. It's going to be mixed, but mental health is going to be a big part of it…so I hope that once the people see the play, they will understand homelessness better and mental health better…I lost my mind. I didn't have control over me and people don't understand it unless you live; unless you go through it. But I understand it now, so I can open up a portal to let other people understand it too.

Racial/Ethnic Contrast: Avoiding Drawing Negative Attention. ***Lacking Fit in Neighborhood.*** Generally, participants experienced an appreciation for neighborhoods that they perceived as being somewhat diverse.

> I'd like to see more, more different races…Because when I see different races, it takes me out of my own…It's good because when I see the Filipino lady and her boyfriend, it's a different race of people, and I get, like, a good feeling. And then, then when I see the white dude come out of the building, he says, "Hi." I say, "Hi." And, I don't know, it's like, I see a different race, it's just different.

They also expressed a general desire to fit in: "I like to be in places where I can be around a lot of people and not be seen. I like to fit in and not be noticed. I just like to be there without anybody noticing me."

When they felt a lack of "fit" due to a perceived significant racial/ethnic mismatch between themselves and the majority of other persons living in their neighborhoods, they experienced lower social connectedness. This was particularly salient for non-Latino participants who lived in predominantly Latino, Spanish-speaking areas. The language barrier made it difficult for participants to interact with others in the community, which resulted in them keeping to themselves: "I don't say anything to my neighbors. I come and go because they are all Latinos. Basically, I just stay to myself." Census data revealed that this participant lived in an area that was approximately 65% Latino, confirming that language differences may indeed pose a barrier. Despite not interacting with community members, this participant still reported feeling at home and comfortable in his neighborhood. As the disparity in neighborhood ethnic proportions grew, however, participants reported not only staying to themselves, but feeling a bit out of place. The following quote is from an English-speaking African-American woman who, according to census data, lived in an area that was 90% Hispanic/Latino.

> I feel a little left out because everybody around here, they talk Spanish…they don't talk English. So I'm left out…I don't know if they're talkin' 'bout me when I walk past or something like that. Yeah….I just stay to myself.

Similarly, an English-speaking White/Caucasian participant, who lived in an area that was 91% Hispanic/Latino, reported how a large ethnic contrast made him feel as if he drew negative attention, which discouraged him from going out.

> I don't go anywhere up here…There's a…group of Jewish people in the neighborhood… and then there's a strong Latin community…so it's a weird dichotomy up here…I don't really feel like a part of this community, I don't feel I fit in, I don't feel that the people like me, or let me be anonymous half of the time.

Such ethnic differences may have amplified the already existing ways in which persons with psychiatric disabilities may be perceived as different from others. Since participants discussed attempts to avoid standing out, a racial/ethnic mismatch may have made them feel as if they further stand out and cannot "pass" for regular members of the neighborhood. Such sentiments led participants to distance themselves from activities and people in their community.

Experiencing Racial Discrimination. Experiences with racial discrimination could also increase the difficulty of being on the streets and getting around. Despite enjoying traveling about the city, participants felt that they risked exposing themselves to prejudicial behavior from others.

> I don't fit in downtown either because they look at me like a Negro…when I go downtown, there could be a person that looks very prestigious, with a suit and a tie on and compared to how I am dressed…I look like a bank robber with a baseball cap. You know, cause I'm dressed in stylish, but they take it for something else – like a threat…so when I go downtown, when people look at me negatively, I think…what the fuck did I do?...I be sitting down with my head down, a person gets up and moves one seat. I am smelling myself to see if I stink or something. I don't smell, and it makes me feel inadequate. I rather stay home where people admire me and I not a threat.

As alluded to previously, for younger African-American men, this fear could extend to being targeted by police on the street. One participant described how it was "hard to be a Black male" who is "always considered trouble" and getting stopped by police. He described this as being particularly problematic when he would visit his mother in Brooklyn, who lived in public housing: "It's hard to walk down the block without police trying to stop you and shit, cause you got a hood over your head. It's cold Goddamn it!"[3] Such challenges discouraged participants from extensive travel around the city and reduced their opportunities for social interaction, particularly if network members (as in the above scenario) lived in areas to which participants

[3] This statement was made at the baseline interview, which took place many years before several recent high-profile media stories which called attention to such incidents.

felt uncomfortable traveling. Additionally, for the participant who felt uncomfortable traveling downtown, these perceptions of prejudice also discouraged him from participating in a rehabilitative service meant to promote socializing.

> I don't go to [the psychosocial club] no more. Because there were people who made me feel out of place the minute I go there…I mean not totally discriminated - cause they know their whole ship will come down if they discriminate against a Black person. So they better take a different approach to make us feel not welcome.

Women Experiencing Controlling and Abusive Relationships. While not routinely inquired about in the interviews, four of seven women mentioned experiencing abuse, including severe physical assault, most commonly by significant others. Abuse ranged from controlling behavior to extreme physical violence. One participant described how physical abuse by boyfriends had been a constant, recurring experience in her life:

> Like, I had sex with guys in the past, but it wasn't a boyfriend. It was beating me up, black eye, beating me up, black eye. Threw a rock at my leg, bust my head. It was that. Believe me, it was that…Took a boom box, and bam, right over my head. It was black, I couldn't see nothing.

Another participant related her experience of her (now ex-)boyfriend's physical abuse for years.

> He used to hit me before, chase me around, stalk me, and all that stuff, you know. He still do it. This was five, four years ago. So now he still does it. He never gonna change. He's never gonna stop calling me a bitch…he's never gonna stop hittin' me, because he done punch me in my face twice, three times on ((holiday)).

Beyond the obvious physical harm that resulted from such violent interactions, experiencing abuse could restrict participants' overall social relationships and interactions in several ways. First, participants described how a partner's jealousy would manifest itself in attempts to control and limit their social interactions, making it difficult for participants to maintain relationships or even have interactions with others:

> He [recent ex-boyfriend] would never want me to go back home. Because he don't know what was gonna happen when I go home. What company I have- he was like, like a shadow…he don't like me with company, wit' friends and stuff like that…He didn't like

> me havin' a job, right. He didn't want me to have a job. He didn't want me talkin' to nobody, so I had to be by myself. When he go, I gotta not talk to somebody come past [me] and say "how you doin'," stuff like that, I can't say, "Hi."
> .

Another participant relayed a similar situation with her current boyfriend in which his jealousy made it difficult for her to maintain friendships.

> John is real insecure…he feels like people be trying to tear us apart. Or people be trying to come between our relationship or people just trying to get with me- you know why. He's loves me a lot and to see a man talking to me…People still be trying to get with me, that's how he feels. So it's hard for him to let me have friends, male friends and what-not. When people be calling my house, he just be wanting [me to] like change my number, change my number. I change my number so many times you know.

Despite recognizing how her boyfriend's jealousy was affecting her ability to have friends, this participant generally thought of her boyfriend as a positive presence. For her, abuse had begun early in life - before she had become a teenager - and characterized much of her subsequent adulthood. Her experience reveals the more subtle (but equally damaging) ways in which chronic abuse can have long-term effects, such as by potentially limiting this participant's ability to critically reflect on how her current boyfriend's behavior might be a red flag.

> I've been homeless since the age of twelve. I wanted to always finish school, my mom took that away because of the age of ((age)) when she threw me out there….I go outside one day, I got raped the first time. The first time lead to the second time, and the second time lead to- so many times I'm raped that I can't count how many times I've been raped. And how many times- and it's like, right, I just have to laugh. I try to forget about it and I be thinking sometimes that shit is going to come back and haunt me because I don't know…

Though she does not connect it to the potential warning signs of controlling behavior with her current boyfriend, she does go on to question how her history of experiencing severe abuse has affected her ability to have positive relationships, highlighting another way in which abusive relationships affect participants' connectedness. She describes the insidious and enduring psychological effects that abuse can engender, leading to a cycle of problematic relationships and the concomitant potential for on-going exposure to controlling behavior and isolation:

> Do I be in bad relationships because I like the beating or do I be in bad relationships because I'm used to getting beat down? And, before, I was hiding because I wasn't sure what I wanted. But right now, I'm really scared to be in good relationships because I don't [know] what it really is for me to be really loved and so I'm not used to people doing things for me, or me going to people for things...maybe in abusive relationships, I think I like it because the reason I get beat down- I think I deserve it. And I think all my life, I've been getting it like that. People have been abusive because I've been so insecure, been like choosing to be the one to get and get, and letting them get me.

Beyond jeopardizing intimate relationships, prior abuse and trauma could also make participants wary of social interaction in general, by compromising their ability to trust others:

> I love living in here- people are so friendly and kind you know. Sometimes the neighbors be inviting me to their house for parties you know, but I don't go. And I think, well, maybe it would make me feel better to go sometimes, but I can't go. I feel like I can't go, but some people be like inviting me to their house for [incoherent], for church. And I just feel like I can't do it there, you know- I be nervous…I be like, I want to go back to church. I be telling myself that I want to go back...Trying to trust people, it's hard for me to trust people you know.

The difficulties of coping with an abusive relationship could also lead participants to engage in behaviors that could further adversely affect other aspects of social integration. The participant who struggled to end her relationship with her abusive boyfriend explains how the stress of that relationship led to heavy drinking, thus jeopardizing both her recovery and her part-time job due to excess drinking: "But sometimes I stress out because [of] this knucklehead and I go do stupid things, like drink a lot…it's like I binge."

In the extreme, abuse could lead to complete social isolation as a result of physical restraint. The experience of the participant who had been abused since childhood is once again illustrative. She recounted how she had been forced into extreme social isolation as a young adult when she was held hostage after becoming homeless:

> I got hungry. I said "Yo, I don't care I need money to eat, to…" So I started doing prostitution...I was hookering and then this pimp he came and picked me up from the street. He gave me his condo to stay at, but I had to give him half of my money. He went and he raped me and forced me to stay with him, so I was hold hostage in his apartment. A couple of times he had people do crazy shit to me…I was never able to get out.

Beyond demonstrating a situation of forced social isolation, this quote also illustrates how participants' lack of access to resources (e.g., housing, money), set the stage for involvement in negative relationships and dependence on abusive partners for material assistance. During years of victimization, participants could be forced to weigh experiencing repeated physical abuse with the possibility of exacerbating their social isolation, as well as losing assistance with basic needs. Other times, cutting off ties to an abusive partner might mean losing a significant connection - however harmful - that participants actually had. The participant with the abusive ex-boyfriend explains how having her boyfriend was helpful as she was adjusting to living in an apartment on her own:

> [It took] a long time [to get used to the apartment]! They thought I just didn't want to live there. They was like, "well, we could give the apartment to somebody else." But I was, 'nah, I need an apartment!" So I had to get used to it. I had to get used to it. So I stay with my boyfriend sometimes and then I come back home…Sometimes when I'm here by myself, it take me a long time to get into bed or turn out the lights and stuff like that…and I sleep on the couch sometimes (laughs)…[At first] my boyfriend used to come here with me.

Another echoed a similar sentiment,

> Right now, it's like when John is not with me, it doesn't feel like home…it's just that when you're not used to being alone, and you ask yourself when you're sleeping alone, "Do you really want to sleep alone?"

Further, distancing themselves from abusive others could also mean losing contact with members of the abuser's network, with whom participants had bonded. The participant above went on to describe her current perspective on this dilemma:

> My ex-boyfriend and his ((relative)). It's kinda- that's kinda stressful too, because I was with them for nine years, so it's like, sometimes I wanna go over there. And sometimes I'm like, "What's gonna be the consequences?" So… I think it's just like best to, like, stay away from them. But I'm gonna miss them. And they nieces and nephew, I was with them. It's gonna be kinda hard, but I guess I can manage it.

Cutting off ties with her boyfriend thus meant losing both the minimal comfort that he had provided, as well as contact with his family, with whom she had bonded. In this context, her recent decision to leave him was finally driven by a realization that leaving or staying had become a matter of life and death, which ultimately trumped the need for social connectedness.

> I fell in love wi' him, but it's like, the lightbulb has to go out. Because I'm gon' end up hurtin' him, or he gon' end up hurtin'[me]…One of us is gon' end up dead… Dead. Done. Yup. And I don't want it to be me, and I know he won't want it to be him.

She then explained how this chronic exposure to stressful relationships has led her to abandon actively pursuing a partner, resigning herself to fate:

> If it's meant for me, it's gon' come to me. I'm not goin' to search for it no more. If a man supposed to come to me and is for me, it's gon' come. If not, I'm-a just have my friends. Like Tim and people that come to my house - they're friends, they could go. I'm alright with that. I'll be straight with that. And just be happy.

Repeated abuse can exacerbate social isolation and the trauma associated with abuse may compromise participants' ability to engage in positive relationships, as well as decrease their willingness to actively pursue connectedness. Because of participants' extreme isolation, and sometimes financial or emotional dependence on the person perpetrating the abuse, leaving an abusive relationship can be difficult. Breaking such ties, however, was considered a positive step despite potentially resulting in more limited social connections once the network around that member was lost.

The Effects of Aging. Since the mean age of the participant sample was 43 (median age 45), approximately half of the participants could be described as middle aged. Some aspects of limited connectedness were attributable to the effects of aging, with participants emphasizing how becoming more mature, dealing with personal health issues, and experiencing the passing of network members posed challenges to social relationships.

Maturation. The process of maturing was associated with cutting back on a more turbulent lifestyle and this was described in ways that demonstrated a direct link to limited connectedness. As participants had gotten older, they had cut back on many of their social activities such as going out regularly, partying, hanging out on the street, or drinking with friends.

> [I'm] not [going out] much. It depends. You know, if I, I wanna go out, then I call one of my friends and we go out. It depends what mood I'm in, you know? I'm not really a party-party type of person. Where I- every weekend I go out, to a bar or club or something. I did that in the past. I'm not tryna do that again. Cause I'm too old for that. I'm forty-six, so I'm too old for it.

Participants indicated that they had developed a new perspective on life and that the social activities they had engaged in previously were no longer as meaningful or valued: "Yeah, I think I am a home guy. I use to love hanging out- forget about it. But now, I did it for a long time, but I don't see the sense in it anymore." Instead, participants now had other responsibilities that took precedence over socializing and going out. The participant quoted below, for example, was taking care of his grandchildren on a daily basis.

> I don't have fun right now. Right now, I don't have room for fun. I am very busy, I have so many things to do. I had fun for a very, very long time. It's time to put away the fun and take care of other things right now.

Another participant's priorities had similarly changed over time from "hangin' out" to working.

> I don't like to hang out with the certain people. In the past I was hangin' out with the certain people, they make me smoke marijuana, they drink a lot. I don't wanna be like that no more. I wanna be come to work…

Struggling with Health Issues. Given that persons with mental illness experience disproportionately high rates of morbidity and premature mortality, they arguably experience advanced aging and have health profiles that are more comparable to older adults in the general

population (Colton & Manderscheid, 2006; Hoang, Stewart, & Goldacre, 2011; Piatt, Munetz, & Ritter, 2010). This was further evidenced by the three participants who were deceased at follow-up. As participants aged, they had to contend with health issues that hindered their ability to pursue social connectedness. A participant who experienced reduced social connectedness from baseline to follow-up explained this effect.

> Things that have been happening to me, like in the middle of the night, I wake up, I'm so dizzy…I don't know if I'm having little strokes or not… but I take aspirin every day, you know, and I basically have made a conscious choice not to integrate or to mingle with certain people…With everything going on with me physically, and um…Impeding my ability to interact more with the people I do know, and impeding me from beginning new relationships.

One of the most common ways that illness impeded social connectedness was by limiting participants' ability to travel around the city. The participant above noted that she still had a desire to socialize but that her extensive physical ailments restricted her ability to get around.

> But um, because of my ((medical condition)) and ((other medical condition)), I can walk around the house pretty well, but for some reason since I've been on insulin, I noticed that I have to stop, like, halfway into a block, to catch my breath…I have been feeling fatigued in my muscles, and I have pain….So it impedes my ability to be mobile. So it's not like I can run down, you know, downtown, to the center, the ((Center)), you know? And I used to be able to go all the time- now I can't go at all. Because between the joints up and down the steps, and I have a, gotta go, gotta go, gotta go girl- I'm always going to the bathroom, urinating- my bladder can only hold so much. I only have so much time between when I leave the house, I empty my bladder just before I put my coat on. And by the time I get to my destination, you know…but basically, no, I'm a homebody. Basically it's come down to that now…I would like to be out more, yes. Very much so.

Participants whose neighborhoods were not the locus of their social activity were particularly affected, since they had to travel further to socialize. One participant, who described himself as experiencing "environmental isolation" in his neighborhood, discussed how his ill health was a contributing factor.

> I was diagnosed with rheumatoid arthritis. In the morning, I'm stiff. It's hard moving and it's painful…On the weekend…the [train] schedule is always wacky and takes a long

> time. I get to Manhattan and it feels very taxing. I'm like- my body is killing me. I want to go home.

Another participant, who had previously enjoyed traveling around the country and meeting new people, also mentioned how aging in general was a challenge for engaging in social activity.

> I'll be honest with you: age also be a factor…Takes a lot of energy, takes a lot of ambition. With age, these things, don't fade, but it just kind of slow down. And older you get, more you get lower and lower and lower, regard energy…Because traveling is not easy.

In addition to physical illness and a general aging effect, weight gain was also identified as a challenge to being more active.

> I come to the groups [at the program]…then I'd go home and watch TV…I stay home and watch TV…[Don't go out] so much. I am immobile with the weight I put on..[I used to] go to the movies, but now I can't- my muscles kill me.

Beyond impacting participants physically and restricting their movement outside the home, health issues and weight gain could also impact participants' psychological well-being, further exacerbating the potential for limited social connectedness.

> So in lieu of maintaining or establishing new relationships- the weight gain that I've had, I have very low self-esteem. You know, I'm very uncomfortable in my body. And, um, I'm getting older you know…

Network Members Passing Away. Related to participants' own health and aging was the experience of network members passing away, particularly family members or friends that they had known from their younger days (cf. Hawkins & Abrams, 2007). This left some participants fairly isolated: "But I don't have many friends anymore. A lot of people died. Now I am the only one alive in my [old] neighborhood. The rest died." While some had lost network members due to natural causes, others had friends, acquaintances, or family members pass away from substance abuse.

> A couple weeks ago- Pedro, he said, "[[Participant name]], me and you are the only ones that are left outta everybody. We the only ones that are left!" Me and him the only one

> left outta everybody…we'd just hang out on the corner, you know, hang out, gamble… I was a drinker, but I wasn't a…I'd go to the bar, have maybe, five beers, six beers, then I'd go home. Liquor, I really wasn't a liquor drinker…But I didn't go every day, every day. Once in a while. But all my friends they- it killed them. Once your liver goes, you're done.

> He [uncle] had a psych history. He and I use to get high and, unfortunately, he would take his medicine and get high at the same time, and it destroys his brain. He would end up sleeping on the bench in the projects and somebody would say "Listen, this guy has been here couple of days. He has not moved." So they called the ambulance. They put him in ICU and then he died…cause you can't mix that medicine with street drugs, cause the street drugs are doing one thing and the meds another and it screws your brain up you know.

The distress of parental loss was particularly long-lasting, with participants still acutely missing their mother or father. Beyond losing the individual who passed away, the death of an integral network member could also create a ripple effect by which participants became more disconnected from other network members. The loss of a key family member, such as a parent, was especially detrimental to maintaining contact with other family members: "[I have] two brothers, but I don't see them since my mom passed away." Similarly, another participant stated: "Last time I spoke to [my aunt and her family], I was, like, 7- after my father died. Like 21 years ago." The possibility of losing a parent could also be challenging. One participant's attempts to come to terms with his parents' impending passing left him feeling both "stuck" as well as needing to distance himself from the family.

> And I'm starting to adjust into life…So I'm pushing more away from my, what you consider, unionable based family, you know, the family in general, the single unit…Well, they're on the verge of passing on…So preparating to go this way in life and move in this way because…Well, [I'm] maturing, getting older. Um, I'm kind of stuck in a big traffic grid with the parents about this um, passing on, you know?

Factors that Facilitated Social Connectedness

Connecting with the Past. Developing or maintaining connections with participants' past facilitated social contact. Connections to the past were comprised of several different aspects

such as living in the neighborhood where one grew up, visiting places or interacting with people associated with one's past, or encountering something that was new but familiar based on previous ties. One participant's social network was largely comprised of his parents, but he also made special efforts to keep in touch with an old family friend to whom he referred as his "best friend."

> I call her Ms. Sanchez, you know, she is a close friend of the family. I feel I can call her at any time… She lives in my old neighborhood…I made a point that I would not call anybody other than my mother or my best friend, Ms. Sanchez… I call her two or three times a month…

Encountering something that was a positive reminder of one's past could also facilitate the development of new connections. For example, one participant noticed a church near her neighborhood that belonged to the religious denomination in which she was raised. Given that she was familiar with the denomination, she was motivated to try attending the church and found herself amidst a supportive group of people who shared her interests: "I always attended [[Denomination]] church since I was a toddler. And when I get around them, it's a good feeling - like we have something in common." Another participant's story illustrated how what could have been a very casual connection at a neighborhood business became a more significant source of social connectedness because of her previous family ties to that locale.

> My barber and I are friends. And, um…the brother I've been with is ironic because, when I first went to see him, he was in the beauty- the barber shop, that once was my ((relative's)) beauty shop…It was like coming back home, you know?... It's nice. It's nice and positive…I feel comfortable. They're usually talking about something, and I agree, or I laugh at it, or they have the television on and the show, a movie's playing, they're all caught up in, yeah.

Living in neighborhoods where they had grown up potentially fostered not only social connectedness for participants, but also a foundation of comfort, attachment, and an overall sense of belonging: "Yeah, I can be myself [in the neighborhood]. They support me, they let me be

myself…I mean, I grew up not far from there, that's my project…I am from the James Projects. Yeah, [this neighborhood's] my home." Another participant reported a similar sentiment: "I used to live out here with my mother. I was young…so it's just like my neighborhood." Physical proximity and connecting with the past meant having instant familiarity with a neighborhood, potentially easy access to an old social network, or the opportunity to join a familiar community: "I walk down this block, and I walk over the bridge. And then I'm on Main St. I get to Main St. and I meet my friends…" Those who did not live in their old neighborhoods but were fairly close by still sought out that connectedness: I see old friends and stuff like that. I go to my old neighborhood….[I feel most at home in] Queens. Cause that's where I was born and raised…Yeah, that's my home territory."

The importance of this type of connectedness was further reinforced by the fact that participants who were missing this connection desired to be closer to people and places from their past. One participant's ideal place to live was Westchester, where he "grew up", and another wanted to return to the Caribbean, where he was born. A participant who felt particularly isolated in his neighborhood described how he envisioned his connectedness would be different were he to live in his old neighborhood again.

> I could live in a one-room apartment on 18th St. That would be my priority. There's still old playwrights and actors that I'd know. My social life would be different. I'd be going out every day. Here, I guess I'm just sitting here waiting to die.

Another participant had grown up in the Bronx, but was living far away from important people in his life.

> Yeah, I have several friends who I'd like to see, but I don't keep in contact with them…Because they live so far from me. That's why I'm trying to move to the Bronx now so, you know, I can be with a couple friends that I hang out with that don't do negative things. Like, hanging out, you know, like friends…My sisters…I don't get a chance to see them. One lives in Pennsylvania and the other one, I hardly get a chance to see her. Everybody lives in the Bronx!

Distance from people and places that had been important to them was a challenge, with participants feeling discouraged by lengthy travel times to see old places, friends, or family members. The most common barrier to moving to certain areas was affordability, with participants citing the difficulty in finding "cheap" apartments. Proximity was helpful, as illustrated by the participant quoted above, who eventually moved to the Bronx by the time of his follow-up interview. While he was still frustrated with his commute and with living "on the other side" from where he grew up, he experienced some increased indicators of social connectedness.

> My other sister, I could see whenever I want. This month, I seen her New Year's Eve. We was hangin' out for New Year's Eve. Me and my sister and my mother. For Valentine's Day, I'm gonna take my mother out to the movies, then we're gonna go to Friday's, steakhouse Friday. Cause they got a special there. Or Applebee's or whatever. It feel good to spend time with my mother. My sisters- egh. My mother, yeah…I have a couple of friends I feel comfortable with. We talk, we talk about things, you know…A lot of my friends got kids so, you know, I really don't get to see them that much, cause they're with their kids. But when we together, we talk, hang out, get a little taste, and we talk, you know?

While maintaining close connections with the past was beneficial for many participants, it was not uniformly positive. Echoing back to the section on how participants purposefully cut ties with network members who abuse substances, immersion in old places and networks could also trigger substance use: "When I came back from rehab, they switch me to 3rd Ave. All my crew is there, so I relapse and they send me to another rehab." Thus participants faced the dilemma of maintaining long-held associations with their past but potentially jeopardizing their recovery. The key appeared to be to maintain or renew associations with individuals from one's past who had similarly made progress in life in terms of moving away from involvement in negative activity.

> I go down to the ((Name)) Park and my friend works out, you know what I mean. He used to get high too, but he don't get high no more. He works out- on that, you know,

> chin bar? Like, he said, do you want to work out? So we went down there and worked out.
>
> Well, these are friends I grew up with, friends I used to hang out with in the park. Everyone was down with the same gang, so we did a lot of things together. So, you know, we're real close. It was back, it was back in the 80's when we did all that stuff. That's old. To me, it's old… we all left that gang a long time ago. We all retired from that. So, it's just, hangin' out and bein' alive, that's what counts, you know? Bein' able to breathe, and be stress-free, not have to watch our backs or worry about things. That's what counts, you know? So, you know…

Taking Care of Others. While acting as a caregiver is generally associated with increased stress and hindering connectedness (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995), taking care of others was actually beneficial to social connectedness for this sample. It offered both a modicum of social connectedness by virtue of a close relationship with the recipient of care and it facilitated other connections as well.

Caring for Aging Parents or Relatives. Participants with aging parents or other older relatives provided support to these family members. Caring for these network members ensured a high frequency of contact since participants visited them regularly and provided concrete assistance and emotional support, thus helping to maintain or increase social connectedness.

> What's most important to me- Is take care of myself. And then, watching after my mom…I see her every weekend. For Saturday and Sunday, sometimes on Friday, you know…We hang out, go to the movies, and stuff like that…But like I said, I just wanna [move] closer to my mom cause she's gettin' old, she has no- her legs not that good, she could hardly- not sayin' she can hardly walk, but you know, she's limpin', so I know the people in that neighborhood, you know…She'd be better off with me.

Needing to take care of his mother translated to more time spent with her and resulted in more opportunities to "go out." This was especially important for this participant who was otherwise not much engaged in social activity: "Like I said, I don't go out too much- unless it's going to see my uncle, or going to see my mother." The participant's uncle was similarly in need of

support and the participant was fulfilling that function for him as well, once again maintaining an important relationship as he did so.

> I went every day this week to see him. I went Monday and Tuesday to see him. I seen him yesterday. So I'll probably see him Friday…I spend a little time with him. Cause he's old. He's like, sixty-eight years old so, you know… And that's family, so… I keep him company.

Participants did not talk about such caretaking responsibilities as a burden, but viewed them positively as an indication of being needed and as a source of pride. Another participant described at length how he cared for his mother before she passed away.

> I think about my mother, but I try not to think about it because it gets me depressed when I think about it because I miss her so much. I used to take care of her. I took care of her for about, maybe it's about, um, nine or ten years…Did her shopping, do her laundry, change her (incoherent), cook for her, mop the floors, do all the windows in the house… You know, I didn't mind, because my sister couldn't do it cause they had to push the window forward. It looks nicer when the windows are clean, I never clean these windows [at home], because I'm lazy and I don't want to, you know what I mean?...But he, he, he, he [father] couldn't take care of my mother. It was hard, you know what I mean? To carry her up and down the stairs, to put her in the wheelchair, to get the oxygen, and the bag for the tank…I picked- the wheelchair's downstairs, then I carry the oxygen downstairs…the tank, and I put it back in the wheelchair. You know, sometimes it was hard, but when I used to wheel her down the street, it wasn't hard for me. My sister used to bump and everything…[my mother] said "My back is killing me from your sister"…But when I pushed her, she never had aches and pains you, know what I mean? She said [to my sister], "You're not taking me outside. You don't know how to push me."

Being a caregiver thus allowed participants to have both a closer relationship with the person for whom they were caring, as well as more frequent interaction with others, such as the father and sister in the case above. It generally served to motivate participants to maintain more consistent contact and be more active.

Carrying Out Parenting Responsibilities. Children were also an important source of social connectedness. Participants who had contact with their children articulated the rewards of involvement in their kids' day-to-day lives.

> I'm generally in my house if I'm not at my kids' mother house. I ain't got nowhere else to go…Honestly, I could see my kids when I want to. I try to see them every weekend. If I don't see them from Friday to Sunday, I go over there Monday and stay the whole week, till like Thursday. I'll take them to school, pick them up, they homework…Yeah, so I tend to see 'em a lot.

Similarly, another participant spent the bulk of his time caring for his grandchildren who lived with his daughter.

> I am helping my daughter out with her grandchildren…On a daily basis, I am cooking. I get up in the morning and take the kids out to school and I take care of some paperwork business…trying to get home in time to pick the kids back up…I have to feed them, help them with their homework, bathe them, give them dinner, put them to bed, and get on with the next day…five days a week.

While he acknowledged that taking care of his grandchildren did not leave much time for other activities or socializing, it also provided him with steady contact with his daughter and her children, which he enjoyed, stating: "I like to talk to the kids."

Having children also translated to having more connection with family members in general and/or spending more time with them. Being there for kids kept families more involved in each other's lives. One participant was frustrated with his sister cancelling a couple of his visits to her home at the last minute and he had decided he was not going to: "go over there anymore." Despite this decision to no longer go on his own, he still stated: "I am going to go next weekend so she could see my daughter." As mentioned previously, another participant saw relatives more as a result of being with his kids.

> I see my older sister more than I see everybody. Cause my older sister's in Brooklyn, and then when I go to see my kids, they in Brooklyn. At the end of the day, if I need somewhere to hang out with my kids, I go to my sister house, so my kids could see they cousins, and, she the closest in Brooklyn, so…

Similar to participants taking care of older relatives, this responsibility was not viewed as a burden but as a valued role. It fostered connectedness and motivated participants to maintain positive trajectories in life.

> That's the love of my life right there: my daughter. That's all it's about, you know. That's my biggest inspiration to keep going and not giving up on myself. Cause if I give up on myself, I'm giving up on her. And she didn't ask to be here.

In contrast, participants who did not have contact with their children, or had highly limited contact, experienced a continued sense of loss and desire for reunification.

> I'm holding on and trying to stay alive for the sake of my kids…I love them, but my kids are hard for me to feel the love of my kids because they were taken away at birth and it's like I can't feel the love. I never had them in my arms, you know, I just gave birth to them and they got taken away…I'm trying to get them back.

> And our children, we've been disconnect for a long time and I really, I don't know where they at…I'd love [to get in touch]. Not just like it, I love it. I wanna see how man they are, how big, I don't know. It's just so many things, you know? I don't know who don't miss their kids. But that's okay for right now. It's not, really, but I'll swallow it. That's the most obstacle thing, thinking about them.

It appeared that men had more contact with their children than women, who faced greater barriers such as having had legal custody taken away, relatives who discouraged or prevented visitation, children who lived out of state, and in one instance, a partner who had kidnapped the child.

Pursuing Artistic/Creative Activities. While involvement in artistic pursuits such as writing, painting, acting, or playing music was beneficial for participants even when done in solitude, it could also foster interaction with others who shared similar interests.

> I am a good writer. I am not saying I am a great writer, but I am a good writer and I want to write plays. I want to do it with Mike cause I think Mike is very talented except he does not have, like, an outlet. I am kind of like that too. I don't have, like, an outlet and I want to create an outlet for the both of us. He's got musical skills, he plays guitar, he is fun. So I am writing a play about mental health and it could be you, how you are treated by society…I tried to establish a friendship with Mike because I want to do this play and it's about time I bring out some kind of material that we can work on together.

Similarly, participants who were into music would find others who were like-minded, and would build friendships around this shared interest or have individuals with whom to collaborate.

> I got a group, a music group, a whole bunch of them…now there's about ten of us…[Doing] hip-hop…This one guy I hang out with [in my neighborhood], we got the same interest in music and stuff like that. He's a cool person.

An art group at the Housing First program was also particularly popular: "The groups keep me going, especially the art group. I love the art group. I like to...hang out." Being immersed in worlds of art or music was beneficial as it could provide a somewhat readily available social network: "Someone knows my work, my sensibilities, call me up and say 'Come in and show us.' I was always getting pulled into some projects. There was always lots going on around me."

Utilizing the internet to showcase their artwork could also open up opportunities for participants to connect with individuals whom they would otherwise likely not encounter. For example, posting professional photographs on an image hosting website that integrates social media helped a participant to connect with someone from Europe.

> I have a ((social media)) account and I post photographs there. Connect with people on ((social media))…There was this guy on ((social media)) who lived in Europe and he was taking care of his grandparents and very depressed. And I know that Europeans like to take holidays. So I was like, come take a holiday here and you can crash on my couch and he did. He came and stayed and we had a good time. We're both vegetarian, we have that in common...we had a few artistic differences.

While some of these connections could be fleeting, particularly if they were based on specific artistic projects, they still presented an opportunity for participants to expand their network for that given time and to benefit from the overall experience.

> I did [writing music and recording] with a couple of friends of mines, but after I done it with them, everybody went they own way…I tried to look for them on Facebook. If I had a chance, yes [I would reconnect with them], but right now I don't have a chance. So whatever I learn from the group, I just do it on my own.

Accessing Neighborhood Distal Support. Participants who felt a greater sense of attachment to their neighborhoods often referred to situations in which neighbors demonstrated qualities such as trust, respect, and caring. These participants mentioned that neighbors would

watch out for each other and that they were tolerant of differences. One participant was pleasantly surprised to come home and find that a package delivered to her was still by her doorstep. She took this opportunity to thank a neighbor for keeping an eye on it, thus meeting her neighbor for the first time. Another participant saw his neighborhood as a place where neighbors respect one another and where he could be himself without being by himself. In some instances, neighbors would provide participants with instrumental assistance.

> I only have two neighbors that look out for me- one don't speak English, but I say, "Comida?" She is nice and gives [food] to me. The other [neighbor] around the corner, he looks out for me. That's how I got this wall unit, this glasses table, the couch over there. That's what you call neighbors.

> I see the super, you know, every night or every other day. We have a very nice relationship. He does repairs to my apartment free of charge. He brought me a Nintendo… ummm, he does repairs in the house and he does it for money, but he does not charge me…We are very close, every time he comes by I have a fruit bowl. I offer him a fruit you know. We have a nice relationship.

Neighborhoods perceived as having these positive qualities yielded more opportunities for positive social interactions with neighbors and others, and these contacts further reinforced the sense of trust and respect that fostered social cohesion.

> I got to know everybody in the area. It's not a lot of violence that goes on. It do, but we don't hear of it. Everybody friendly. I used to help a old man in my building, like, years ago. Now he's in a nursing home. And just to see the kids grow up, that I been in this area for so long now, that I've seen 'em grow up and it's kind of a thing now, and everybody know who I am, so…I speak to the mail lady, I say hi to her. I say hi to my next-door neighbor… I just generally say hi to people: they hold a conversation with me, I conversate back. Like, Maria downstairs on the first floor- she's a old lady. She know what I did for her friends upstairs, Mr. and Mrs. Gonzalez. Like, you know, people know me for the kindness…

While these casual connections, or distal supports (Townley, Miller, & Kloos, 2013; cf. Granovetter, 1983), may seem somewhat trivial, their contribution in helping set an overall positive tone for neighborhood belonging and connectedness is highlighted below:

> I get up every day five o'clock in the morning, I go work in a candy store...I work in a candy store. I set up the papers...The guy don't pay me too much...the lady on Sunday, she sells this Mexican, uh, this Mexican food- it's called uh, tamales. I buy off of her, you know what I mean? She don't understand English, I say how much are they? Uh, one peso, one peso- she means one dollar, so I say gimme two, you know. She stands out in the fucking cold. But she does it right- she sells a lot of them you know. And I buy the paper from the lady- instead of buying the paper in the store, I buy the paper from the Spanish old lady- she's trying to make a living, I buy the paper from her, you know what I mean? I have my coffee at McDonald's. It's nice at McDonalds during the daytime…they're a couple of people I see every day, I say hello I mean, it's nice and peaceful.

Despite not representing the types of intimate relationships that participants desired, they staved off isolation and offered a sense of belonging, as well as the opportunity to help others, while providing instrumental support or positive feedback for self-worth. As discussed in the section on hindering connectedness, however, there was still potential for becoming involved in negative activity as a result of greater neighborhood connectedness, especially given participants' poverty. For example, the participant above, who received food and furniture from his neighbors, attempted to supplement his income by offering the temporary daily use of his apartment to others for a fee, which eventually caused problems in the building and led to his eviction.

Accessing Neighborhood and Local Resources. Despite describing their neighborhoods as "ghettos" or as places where one had to be concerned about illicit activity, participants also thought these areas were well-resourced. Neighborhoods were described as places that had sufficient amenities and businesses, as well as satisfactory access to transportation.

> There is nothing that I dislike- all the stores are nice…Yeah, there is like a mini mall. A Dunkin Donuts, there's a coffee shop. Everything is very convenient. I don't even have to walk to the bus. I guess the only thing I would like is a park…

> Here, this is alright. All the stores are around here: the clothes store, the mall is right here. [Program] is right there. I don't have to take a bus to go to work…I just walk there- is a ten minutes' walk…The train station is right there.

The accessibility of these resources was conducive to participants developing routines of daily living and leaving their homes to utilize local businesses or public resources. This allowed them to become more familiar with the people in their neighborhoods, thus increasing the likelihood of fortuitous social encounters.

> I am starting to talk to people. They are starting to recognize my face and talking to me…I like the park…It has a tennis court, an animal court, a bike park, a skateboard park for the kids. It's really nice…I think that the neighborhood has it all…It's a dream come true for people that like to be with active people…we have libraries, post office-everything.

Unlike negative neighborhood aspects such as illicit activity, which participants appeared to discern sometimes rather intuitively, they had to be willing to explore their neighborhoods to find these local amenities.

> I was walking around and I discovered a nice little African boutique store that I never even knew was there. And this restaurant that just opened up…and they got some good food in there…And I was looking around and I found the laundromat that I didn't even realize was there.

Participants would also travel locally for leisure purposes and to access entertainment. Some participants simply liked to get out of the house and go somewhere for a change of scenery, simply walking around other neighborhoods or going window-shopping.

> I just go walk, and I walk… I go to the Bronx. I like taking trips to Brooklyn…being in the house is like a feeling of being caved in and sometimes I need to get out, dust off, let the air in my head…

Others would visit parks, the zoo, shows, sporting events, concerts, and other venues. These activities could increase the likelihood of having casual interactions with other community members: I walk from eight o'clock in the morning till eight o'clock at night. I come in tired. I see people, see things, free shows, food courts. You see things without expecting it. Free concerts in Central Park…" Another participant commented:

> I meet people in ((Name)) Park all the time: girls, like, guys – I meet people. Everywhere I go, I meet people. I told my friend Mark, I said, "Come to ((Name)) Park, you'll meet somebody there. I'm tellin' you, there's a lotta nice girls on the great lawn….I guarantee, you'll meet a girl in the park, talk to her." Cause I always do.

Having Employment and Volunteering. Most participants who were working were employed part-time (e.g., 10 hours per week) by the program. Having a job provided participants with an activity to engage in outside their home, especially since many reported that their routines only included working for a couple of hours and spending the rest of their time at home alone. It also provided participants with opportunities to demonstrate competence and to feel needed.

> It gives me something to do. It helps with the finances. It, uh, it makes me feel needed…I remember when [staff] was here, I was answering the phones and she complimented me, "You sound just like a professional." And that made me feel good so I just continued doing it. And now I'm doing messenger stuff besides answering the telephone…[I like the] messenger [better]…It, um, I don't get out that often (laughs).

Another participant similarly emphasized how having a job exposed her to positive social interactions that boosted confidence and self-worth.

> I tell 'em what I'm cookin' and then when I'm finished it's like, I say, "Do you want some?" So they do and when I finish, they give me compliments sayin' "It was very good." Or stuff like that….my self-esteem go up higher and try to do more better at it, you know…It keeps me occupied. It keeps my mind off a lot of stuff for a couple of hours, you know.

Regardless of the specific job description, working was often conceptualized as "helping others," which made it more rewarding for participants.

Additionally, work provided participants with direct opportunities to develop social connectedness, especially with program staff, with whom participants established closer relationships. This was highlighted in the context of the program's announcement just before the follow-up interviews took place that it was changing the structure of clients' employment. Work positions were becoming temporary and the goal was to help individuals obtain employment

outside the program. However, the relationships and the acceptance, comfort, trust, and respect that participants had found at work made them extremely hesitant to seek employment outside of the program.

> Um, I try to do the best at work that I can, and I know I have this job for the next year, but I'd really like to stay instead of being farmed out or outsourced through the [employment program], you know. That I happen to be one consumer that really wants to stay with [the program], and *needs* to- psychologically. *Needs* to. Because it's become my family.

> [I: Do you wanna get another job?] No…cause I know them and they're my friends, you know. I know them for a long time. So I wanna keep it like that…I love my job…I love workin'. I got something to do. Helping people, when [staff member's] not here. I'm here to help her out. She can call me and say, "You comin' to work? Because I'm not comin' in." I came in today, they said, "You workin' today?" I say, "Why, [Staff member's] not here?" They said, "No." I said, "Ok, I'm here." I worked till four, I worked till four-thirty. That's extra time on my time sheet. And that's good for me, you know? And that's good that they can trust in me…And that's what I'm gonna miss about it.

Volunteering was also described as creating opportunities for developing social connectedness or for facilitating exposure to activities in the community that could serve as a platform for broader integration, though the relationships were not as close.

> You volunteer when you can…you need people to serve and clean up…I have known these people for five or six years. I know some for eight years because I go [to church] every Sunday.

> I volunteered…It's a organization intended to provide recreation for people with disability. I worked for them for quite some time and during that time they got me to like some of the things I like now: learn how to go to the theater, Broadway shows, musicals.

While work was generally seen as a positive responsibility, it was also described as a potential source of stress that needed to be managed to avoid jeopardizing one's wellness.

> Um, it was too much for me at first, um, I don't know, I just couldn't- I couldn't work the hours, so we had to cut it down…so we just cut it down to Tuesdays and Fridays. The pressure. Like all the stuff that goes on in the office, I just couldn't cope with it…I don't know, like, when people be calling and you gotta get the caseworker, answer the phone - maybe the caseworker ain't here - and the caller would call back, and start complaining, and ain't nothing I can do about it.

CHAPTER FIVE:

Conclusion and Implications

Using qualitative research methods, this study sought to understand the factors that facilitate or hinder social connectedness among formerly homeless persons with SMI. Through semi-structured qualitative interviews, participants provided their practical knowledge of the social world. These interviews resulted in the type of rich data that Williams and colleagues (2003) describe as "knowledgeable narratives" that offered an understanding of participants' "contextualized rationality." Specifically, interviews captured some of the complex deliberations about the trade-offs - potential benefits and likely risks - that might be involved for individuals as they reflect on and contemplate social relationships and social interactions.

In line with previous research (Hawkins & Abrams, 2007; Padgett et al., 2008; Tsai et al., 2012; Yanos et al. 2012), the study found that social connectedness is generally low among individuals with SMI who have experienced homelessness. Further, interviews revealed limited progress in the domain of social connectedness over the course of eight years in a Housing First program. This was generally attributable to an underlying ambivalence regarding social connectedness from the perspectives of people with SMI. On the one hand, individuals valued the privacy and solitude of being at home and were content with spending their time alone; on the other, individuals also expressed concerns regarding loneliness and when discussing what was missing in their lives, the subject was overwhelmingly in the domain of social connectedness. Findings regarding appreciation of solitude are similar to Padgett and colleagues' (2008) findings among a similar population. Despite valuing their peace and privacy, however, individuals in this study also desired more relationships with an important other – most often a romantic partner, friend, or child – and emphasized the need for relationships that were

characterized by reciprocity, trust, and intimacy. Individuals' actions regarding social connectedness were generally characterized by social distancing – a purposeful limiting of social interaction, yet their desires still reflected a longing for close others as discussion partners, as company for engaging in activities (e.g., going out to eat or see a movie), or for maintaining or developing a family.

While participants may have described themselves as loners, this identity was likely not an inherent personality trait, but developed partially in response to the learned negative consequences of involvements in social relationships. People in general tend to have fairly consistent expectations and readings of the overall supportiveness of social environments and these "support schemata," while influenced by early attachment, are also informed by life experience (Pierce, Sarason, & Sarason, 1996). Similarly, individuals' perceptions of potential risk/threats in social environments are also biographically informed. For these participants, a legacy of disappointing and harmful social interactions influenced them to develop a very cautious stance towards engaging in social interaction and relationships. The ambivalence regarding social connectedness was thus rooted in a larger tension between participants' desire for connectedness and the need to protect personal resources, recovery, and overall well-being.

Individuals in this sample generally described involvement in social relationships that had exposed them to negative consequences including housing instability, victimization (e.g., intimate partner violence), substance use relapse, and stigma. For example, individuals found that members of their social network often turned to them for direct assistance with money or housing. Because participants had few resources with which to meet basic necessities (e.g., very limited incomes, subsidized apartments), sharing these resources could potentially create significant setbacks and make daily survival more tenuous. In order to avoid such predicaments,

they cut off or avoided certain relationships. Social distancing thus emerged as a strategy for minimizing exposure to risky situations and often occurred for practical reasons of self-preservation. While still desiring attachment, this pattern of social interactions exposed individuals' vulnerabilities and made them highly risk-averse when considering pursuing connectedness. As Padgett and colleagues (2008) note, "losing ground [in recovery] could be sudden and disastrous, and staying the course often meant being stuck on a plateau with few options for positive change" (p.337).

This "preference" for isolation conferred a certain degree of safety and security, preserving stability and resources that meet basic needs. This potentially warrants a comparison to Maslow's Hierarchy of Needs which speaks to the necessity of meeting basic needs, such as physiological ones (e.g., food, shelter) and safety (security of body, resources), before being able to pursue love and belonging (e.g. friendship, family) (Maslow, 1943). In this way, individuals' deliberations reflect this hierarchy wherein a precarious hold on basic necessities and safety precludes the ability to pursue the higher-order need of love and belonging.

While social distancing may come across as a maladaptive coping mechanism that leads to isolation, it is more readily understood when taking into account the social conditions/context in which individuals live their lives. Participants' experiences with substance use, homelessness, and psychiatric treatment are all likely to play a role in fostering isolation. Similar to Padgett and colleagues' (2008) findings, the desire to maintain recovery from substance use was often in direct conflict with maintaining or expanding social connectedness. Given that participants ended previous relationships with substance users, many found themselves with depleted networks and few friendships (Alverson, Alverson, & Drake, 2001; Padgett et al., 2008). Rebuilding a network may have been particularly challenging, as this population of individuals with SMI encountered

difficulties in attaching to traditional recovery communities. For many of them, their informal harm reduction approach to substance use recovery conflicted with mainstream principles of complete abstinence, thereby closing off a potential network of former users.

Additionally, given that most participants had spent years living on the streets, in shelters and drop-in centers, or in congregate residential treatment arrangements (e.g., psychiatric hospitals or therapeutic communities), they may have isolated upon obtaining secure housing to counteract a history of extreme privacy loss and chronic exposure to institutions of social control (Feldman, 2004; Padgett et al., 2008; Ware et al., 1992). Thus, isolation may also be a direct result of the nature of treatment and residential settings that people with SMI have experienced. As Padgett (2007) notes, clients' descriptions of living in their own apartments often reflect the conditions of ontological security - a sense of continuity, stability, trust, and presence in the world. Home becomes a newfound sanctuary and isolation may be consistent with Corin & Lauzon's (1992) interpretation of positive withdrawal as a necessary period of retreat and personal regeneration. Participants' descriptions, however, suggest an additional range of factors related to the social conditions in which they live that set the stage for problematic relationships and that sustain social distancing.

Hindering Connectedness

Individuals described much of their social environments as characterized by poverty, prejudice, discrimination, and illicit activity. These social contexts may influence the likelihood of their experiencing and identifying certain relationships and situations as threats and stressors. Similar to theories that individuals develop negative health behaviors "as responses to adverse conditions imposed by broader social and economic structures" (Lynch & Kaplan, 2000, p.13),

individuals with SMI may engage in social distancing as a response to negative situations, the exposure to which is shaped by these same phenomena.

Indeed, many themes reflect upstream factors that influence people's opportunities to develop social relationships and likelihood of experiencing negative consequences, including residential segregation, racial discrimination, stigma, disability policies that yield inadequate incomes, poverty in general, and concentrated poverty in particular (Berkman, Glass, Brissette, & Seeman, 2000). This resonates with existing theories which argue that "poverty, segregation and isolation, prejudice and stigma, and constrained opportunity structures….influence the type of stressors that individuals experience, their interpretations of those stressors, and the resources they have to cope with those stressors" (McLeod & Nonemaker, 1999, p.322). Generally, persons of low SES – such as the individuals in this sample – experience more negative life events and chronic stressors, and are more likely to be adversely affected by these events (McLeod & Nonemaker, 1999). Similar to the ways in which more distal factors have been posited to influence exposure to health risks, resources, and the adoption of health behaviors (Link & Phelan, 1995; Lynch & Kaplan, 2000), these findings suggest that similar factors may also influence access to social networks and exposure to risk, as well as individuals' social behaviors. Additionally, recent research has found that negative life events, such as residential moves or job loss, are much more predictive of changes in social networks among persons experiencing onset of mental illness than psychiatric symptoms or stigma (Perry, 2014).

Individuals with SMI tend to be of low SES and not engaged in mainstream employment or educational activities that might otherwise serve as contexts for developing social networks (New Freedom Commission on Mental Health, 2003). Given their reliance on disability incomes, they tend to live in extreme poverty. In this study, living on such limited incomes meant that

basic necessities accounted for almost all of individuals' funds and left little room for disposable income that could be spent on more social pursuits, such as going out to eat, attending social events, or regularly visiting or staying in touch with family. Wilton (2003; 2004) similarly found that limited financial resources hindered participation in social activities or culturally valued social exchanges (e.g., buying birthday gifts), thereby thwarting individuals' best efforts to sustain relationships. As emphasized by participants in this study, without sufficient incomes, they were forced to choose between spending money to foster connectedness or preserve basic necessities.

The role of limited resources in setting the context for such tragic choices was further illustrated by participants' prior history of extreme deprivation and homelessness. Unable to meet basic needs on their own, they were more likely to engage in social relationships that were negative but that served to provide basic necessities. Women were especially vulnerable to such dilemmas and had endured abusive relationships because these connections facilitated access to stable housing. After having secured their own housing and basic resources through the program, participants now had more freedom to distance themselves from such relationships. Nevertheless, for women, desires for connectedness could continue to result in involvement in abusive relationships. These relationships provided a modicum of connectedness but, once again, at the expense of their safety or well-being.

Poverty within participants' social and family networks also contributed to distancing and isolation. Participants shielded themselves from requests for money from family and friends, many of whom may have viewed the participant's social security benefits as a relatively stable, reliable source of income compared with their own tenuous incomes. Feeling compelled to share their income or housing with network members experiencing financial crises or homelessness,

individuals could find themselves without sufficient income or with guests who have overstayed their welcome. While norms of reciprocity and resource-sharing have been noted as key to survival on the streets (Snow & Anderson, 1993) and in making transitions into housing (Ware, Desjarlais, AvRuskin, Breslau, Good, & Goldfinger, 1992), individuals who continue to share their newfound assets once housed may jeopardize their own housing stability. When poverty is endemic, fostering isolation is one solution to avoiding such predicaments.

Individuals with SMI also described living in disadvantaged neighborhoods, which may also play a role in influencing associational opportunities and conditioning exposure to stressful social situations. Residential segregation, which results in neighborhoods divided along SES or racial/ethnic lines, contributed to participants living in areas of concentrated poverty, where affordable housing is most often located (Orfield, 1997). This residential segregation, concentration of poverty, and scarcity of affordable housing leads to constrained economic, residential, and social opportunities. It can also hinder the development of bridging and linking social capital (Hawkins & Abrams, 2007), perpetuate more homogenous social networks, and limit the effective deployment of social resources as a result of limited economic resources (Altschuler, Somkin, & Adler, 2004).

At least one study has found that persons with SMI tend to live in more disadvantaged neighborhoods that have "higher levels of physical and structural inadequacy, more drug-related activity, and higher levels of crime" (Byrne, Bettger, Brusilovskiy et al., 2013, p.786). The ways in which individuals in this study described their neighborhoods resonated with these overall features of disadvantage. Further, perceptions of criminal activity and victimization may negatively impact persons with SMI in particular, with at least one study showing that this population is one of two groups whose fears of crime are disproportionately associated with

constrained spatial and temporal movement (Whitley & Prince 2005; Whitley, 2011). While participants' prior experiences of victimization and trauma may have left them more on guard or hypervigilant for possible threats, it is also plausible that these perceptions reflected a cluster of factors that indeed continued to place them at greater risk of victimization. Persons with SMI experience disproportionately higher rates of victimization (Teplin, McClelland, Abram & Weiner, 2005) and those who have been homeless have an added risk (Padgett & Struening, 1992). This, combined with living in neighborhoods with greater illicit activity, could elevate the potential for being victimized or lured into substance abuse and choosing to isolate to avoid such scenarios. Isolating in response to such perceived conditions has been documented among persons without mental illness as well (Caughy, O'Campo, & Muntaner, 2003; Klinenberg, 2003). McLeod and Nonemaker (1999), for example, note that the "constant vigilance that is required to negotiate such environments…causes mistrust which leads to isolation" (pp.329-330).

In addition to becoming victims of crime, individuals were also concerned about being implicated in criminal activity. The potential validity of such concerns is substantiated by research which has found that compared to the general population, individuals diagnosed with mental illness are more likely to experience contact with police and arrest (Lamberti et al., 2001; Morabito, 2007) as well as to have their probation revoked and to be re-arrested (Skeem & Louden, 2006). Though individual factors related to mental illness may partially account for increased risk, individuals with SMI also share a constellation of factors associated with social disadvantage that account for greater risk of contact with police overall. These include substance use (Cosden, Ellens, Schnell, & Yamini-Diouf, 2005; Mueser, Essock, Drake, Wolfe, & Frisman, 2001), unemployment (Harrell and Roman, 2001; Peters & Murrin, 2000), poverty (Lamberti,

2007), lower educational attainment (Draine et al., 2002), and histories of homelessness (Stephen, 2001; Ford, 2005) and trauma (Green, Miranda, Daroowalla, & Siddique, 2005). These factors are all associated with increased risk for incarceration and all are more likely to be experienced by persons with SMI (Draine et al., 2002). Fears of police contact may, therefore, be quite salient. In order to stay out of jail and protect their freedom, individuals avoided socializing altogether or enacted multiple contingencies that limited social interactions which were associated with increased risk. Relationships with peers were, therefore, especially susceptible to such avoidance since these individuals lived in similar social contexts or shared similar backgrounds that placed them at increased risk.

Further, issues of race/ethnicity and potential discrimination may also play a role in setting the stage for increased risk of arrest and incarceration. Participants' concerns may reflect larger controversies regarding racially-biased police targeting, particularly in New York (Goldstein, 2013), and the vastly disproportionate rates at which Black/African-American men are arrested and incarcerated (and the growing disproportionate rate of Latino/Hispanic men) (Mauer & King, 2007), even when rates of offending are similar (ACLU, 2013). Thus, participants – who were overwhelmingly African-American and Hispanic/Latino - may have been particularly focused on avoiding police contact by limiting time outside their home and overall social interaction.

Additionally, issues of race/ethnicity may have also helped shape social behaviors by influencing individuals' perceptions of belonging in certain neighborhoods. Persons who found their racial/ethnic background in a small minority in their neighborhoods of residence restricted their movements or social interactions to avoid feeling out of place or sticking out. Such salient demographic differences by geography are evidence of continued racial/ethnic segregation,

denying persons with SMI their stated preference for neighborhoods that are ethnically diverse (Yanos et al., 2004). Given that this finding was largely driven by non-Hispanic/Latino individuals living in predominantly Hispanic/Latino areas, it may be consistent with prior research which suggested that proportion of foreign born individuals in a neighborhood was more predictive of sense of community than explicit racial/ethnic match (Yanos et al., 2007).

Overall, mental health stigma presented a challenge for participants by impacting a range of dimensions of social connectedness: from a fundamental sense of belonging and personhood, to maintaining and developing social relationships, to being able to assume mainstream social roles. Social distancing once again emerged as a strategy for avoiding stigma, with participants intentionally restricting contact with community members (to avoid potential stigma or victimization) or with peers (to avoid triggering stigma by association). Further, given their other potentially marginalized identities, participants illustrated how stigma with respect to mental illness constituted just one additional layer that complicated social interactions. The concept of multiple and complex stigmas emerged as prejudice or discrimination regarding gender, sexual orientation, or race/ethnicity intersected with mental illness to impede the pursuit of connectedness. Despite these overwhelming challenges, however, having a regular tenancy appeared to mitigate some aspects of mental health stigma. These tenancies allowed individuals to develop identities as community members, regardless of psychiatric disability, and to assert their right to a place in the community. An explicit mission of combating stigma also motivated some participants to maintain recovery and pursue broader social integration.

Finally, social distancing and limited opportunities for social connectedness were subject to life cycle effects as well as deteriorating health. Generally, social connectedness, as measured by social network size and closeness, decreases as individuals age (Cornwell, Laumann, &

Schumm, 2008). Participants in this study described losing interest in behaviors that were potentially troublesome (e.g., hanging out, drinking, partying) as they got older. As a result of this maturation process and withdrawal from these activities, opportunities for socializing were reduced. Further, many developed physical health issues which negatively affected their ability to engage in social activity. Physical health challenges impeded their motivation and mobility, and/or placed them in a position where they needed to avoid socializing in order to focus on addressing health issues. Given that individuals with SMI have disproportionately higher morbidity and premature mortality (Colton & Manderscheid, 2006; Druss, Zhao, Von Esenwein, Morrato, & Marcus 2011; Lawrence, Hancock, & Kisely, 2013), health issues are likely to impact them at younger ages and more severely, setting the stage for isolation earlier in the life course. The finding that participants lost network members to dying is similar to Hawkins and Abrams (2007). Network members passing away was related both to substance use, reflecting the higher likelihood of individuals with SMI being involved in networks of users, as well as life course challenges, such as parental loss.

Why social distancing? The degree to which individuals with SMI played an active role in fostering isolation certainly varied: they had very little control over losing network members to passing away, but played a more active role in limiting connectedness if, for example, they perceived threats to their housing. In most situations, however, individuals described making active choices that involved sacrificing connectedness for preserving another fundamental need (e.g., housing, money, personal safety, health, etc.). Such scenarios resonate with the notion of "tragic questions," discussed by Nussbaum (2000b), which represent situations in which individuals find themselves having to choose between equally unpalatable options that, regardless of the ultimate choice, involve egregious sacrifices for the individual. In this case,

individuals with SMI were, in essence, faced with either choosing between abandoning social connectedness and being alone or risking their resources and well-being. Tragic questions thus lead to individuals having to make tragic choices, including having to make a trade-off that is morally unacceptable – in this case, forfeiting pursuit of the fundamental need for social attachment.

In essence, participants developed social distancing as a coping mechanism for dealing with potential threats. By avoiding connectedness, they tried to limit their exposure to the potential risks associated with social relationships. The question arises as to why social distancing was used – sometimes to the point of isolation - and not other more potentially balanced approaches for managing risk. Several factors which make it harder for this group to manage risk and the requisite stress may account for why participants used withdrawal and avoidance as a primary coping mechanism. First, experiencing SMI and psychiatric symptoms is itself a chronic stressor (Robilotta, Cueto, & Yanos, 2010). Individuals' ability to cope with other types of stress may be hampered by the on-going need to manage stress associated with SMI. Second, chronic poverty also entails "exposure to multiple physical and psychosocial stressors," (Evans & English, 2002, p.238) which compounds risk and elevates potential distress. If individuals face multiple stressors, the removal of any potential threat reduces the overall danger to their resources, as well as the demand on their system, and represents an efficient way of ensuring that they do not overload themselves. Third, by virtue of their lower SES, individuals with SMI have fewer material resources overall with which to cope with stress and buffer risk, thus making the potential consequences of negative events more severe (McLeod & Nonemaker, 1999). Fourth, self-efficacy and mastery have been identified as critical personality resources for dealing with stress (Thoits, 1999). Since low SES is associated with reduced mastery and sense

of control (McLeod & Nonemaker, 1999; Mirowsky & Ross, 1983), formerly homeless persons with SMI may be more likely to appraise environmental stimuli as potential threats and to have fewer intrapsychic resources to cope with them. The legacy of negative experiences within a disempowering mental health treatment system may have also eroded individuals' sense of control and self-efficacy (Kilian, Lindenbach, Löbig, et al., 2003).

Given social conditions that perpetuate difficult relationships, and a limited sense of control that is likely to extend to the domain of social relationships, developing more nuanced boundary management or attempting to engage in a more selective seeking of social connectedness can be challenging. Instead, given exposure to multiple stressors, increased vulnerability to their negative effects, limited material resources, and a sense of powerlessness, individuals with SMI may be more likely to choose to avoid social relationships and their perceived risks. Parallels can once again be drawn to Williams' (2003) findings regarding how individuals living in disadvantaged conditions adopt negative health behaviors. Those qualitative interviews suggested that developing alternative behaviors can be difficult because we cannot

> assume a freedom to make healthy choices that is out of line with what many lay people experience as real possibilities in their everyday lives…The respondents…were also aware that the risks they faced were part of social conditions that they could do little to change. For these working class Salfordians the 'way of life' – in this case unemployment, poor housing, low income, stressful and sometimes violent lives – provided a context for 'making sense' of smoking, drinking and drug-taking…" (Williams, 2003, p.147).

Similarly, this study's qualitative findings suggest that for persons with SMI, understanding the social conditions in which they live provides a context for "making sense" of social distancing and how their disadvantaged position limits their freedom to pursue connectedness.

Facilitating Connectedness

While study interviews depicted a fairly consistent picture of strained relationships, disadvantaged social conditions, and social distancing, the data also suggested several factors that prevented complete isolation for persons with SMI. Despite describing their neighborhoods as places of disadvantage, individuals also described these areas as being fairly rich in local resources and amenities (cf. Metraux, Brusilovskiy, Prvu-Bettger, Wong, & Salzer, 2012). This encouraged them to maintain some level of engagement with their neighborhoods and potentially increased their chances of developing distal supports (Townley, Miller, & Kloos, 2013). Well-resourced neighborhoods also encouraged individuals to be fairly strategic with respect to the avoidance, generally avoiding the people and areas that they perceived to be problematic without having to resort to complete isolation and confinement in their homes. Further, despite noting conditions of disadvantage, some participants also characterized their neighbors and neighborhoods with positive qualities such as trust, respect, and caring. Such perceptions resonate with aspects of neighborhood social cohesion which has been found to positively influence individuals' sense of community or sense of fit in their neighborhoods (Yanos et al., 2007). Physical proximity to familiar people and places also fostered a sense of comfort and belonging, and was important since many individuals perceived extensive travel times to visiting others a barrier to greater connectedness. Simultaneously, however, this proximity and familiarity also carried with it the potential for individuals to fall back into negative behaviors if they remained immersed in negative social networks.

Similar to Hawkins & Abrams (2007) who found that some individuals with SMI and substance use disorders "'rebonded' with old, tenuous ties, while others chose or settled for social isolation" (p.239), this study finds that maintaining or rebuilding relationships with past network members posed one of the few viable alternatives to social isolation. While these types

of relationships may not increase individuals' social capital because they tend to be with persons who are of similar backgrounds and social status (Hawkins & Abrams, 2007), maintaining or seeking out those previously-present network members who represent a positive presence may allow individuals with SMI to derive the basic benefits of social affiliation. Such relationships usually included becoming closer with family members who were supportive of the individual (and not judgmental regarding their mental illness) and longtime friends who had also stopped engaging in negative behaviors (e.g., illicit activity, problematic substance use). These relationships were characterized by intimacy and trust; relationships which did not require individuals to be on guard for potential harms. This option was, however, more available to men than women, who did not report such re-bonding. While study data did not provide insight into this gender difference, it is possible that women had fewer or poorer quality relationships that were less likely to be repaired. Adequacy of family support appears to play a stronger influence in predicting women's homelessness than men's (Caton, Shrout, Dominguez et al., 1995), suggesting that by the time women become homeless, they have already burned their bridges or exhausted all their support, making it harder to later reconcile with others. Such gender-based differences are substantiated by findings that, prior to becoming homeless, women are afforded greater accommodation with family members, literally and figuratively, as compared to men (Hopper, 2003). This results in women having longer stays with family, but may also mean that by the time they are asked, or choose, to leave, their relationships are under greater strain or more disrepair than men's, potentially leading to a point of no return.

While caregiving can generally compromise social connectedness (Aneshensel, Pearlin, Mulan, Zarit, & Whitlatch, 1995; Skaff & Pearlin, 1992), for individuals in this sample, it represented an opportunity to engage in positive relationships. Caring for others was one of the

few traditionally socially valued activities in which individuals were engaged. Such relationships allowed individuals to demonstrate their ability to be responsible and accountable - indicators of "moral competence" highlighted by Ware and colleagues (2007) as critical for connectedness. Further, by giving individuals an opportunity to exercise such competencies, these relationships boosted self-esteem and self-efficacy. Involvement in the lives of their children additionally gave individuals a sense of purpose and motivation. Interestingly, parenting also expanded connectedness by encouraging individuals' involvement with other family members. Caring for older relatives also potentially offered individuals the ability to reciprocate care that they had received earlier in their lives.

Employment represented another opportunity for engaging in a socially valued role and fostered positive social connections. Almost all individuals who were working were employed on a part-time basis by the program and had been so for several years. They described the employment as having a positive impact on their self-perceptions as well as changing the nature of their relationship with the providers. Similar to taking care of others, these jobs allowed participants to demonstrate their trustworthiness, responsibility, and dependability. Individuals also received positive feedback which boosted their self-image and self-worth. Further, through work, individuals had not only assumed the role of a colleague, but came to view their provider co-workers as "friends" or "family." Working within the service agency had both benefits and drawbacks for social connectedness. The agency's non-judgmental atmosphere, its longstanding practice of including peer specialists as full members of clinical teams, and the fact that participants had been employed there for several years created a culture of acceptance and a blurring of hierarchies between "consumers" and "employees." Simultaneously, however, these social relationships were inherently constrained by the fact that providers would have to maintain

boundaries that ultimately limited these working relationships from transcending beyond the workplace or beyond a provider-consumer relationship. Nevertheless, relationships with co-worker providers were a source of positive connectedness and emotional attachment for participants.

Finally, involvement in artistic or creative activities afforded individuals with opportunities to meet or socialize with others around those particular interests. While the overall therapeutic benefits of involvement in creative activity, such as art or writing, have been documented for people with SMI (Lloyd, Wong, & Petchkovsky, 2007), their role in facilitating social relationships with non-peers has been less of a focus. As opposed to other types of potentially social activities (e.g., sports), artistic activities in this study were more rooted in individuals' basic identities and tied to a deeper sense of purpose and personal life projects (e.g., writing a play, recording a music album). Involvement with others was instrumental to achieving these goals so individuals were more motivated to make connections. Further, these activities were often associated with well-defined venues or institutions for networking (e.g., theatres), or were conducive to meeting people online, which expanded the range of available network members. While these artistic pursuits were conducive to meeting a variety of individuals, however, a potential drawback was the potentially fleeting nature of these relationships – especially if they were tied to specific short-term projects - or their potentially narrow focus - if they generally revolved only around those creative activities.

Implications for Practice

Individuals desired greater social connectedness, particularly for relationships that could be characterized by trust, intimacy, and reciprocity, but their extended history of negative interactions also led them to adopt a very cautious stance towards engaging in social

relationships. Boydell and colleagues (2002) similarly observed that persons with SMI perceived social relationships as beneficial, but difficult to manage, and so often withdrew, although those findings related distancing more directly to mental illness. In this study, persons with SMI perceived social environments and relationships as stressful and imbued with potential threats that posed a risk to their personal freedom, resources, recovery, and well-being. Social distancing was, therefore, employed as a way of minimizing these risks. Yet, within the consumer recovery movement, it is well-recognized that progress and growth require risk. As Young and colleagues (2008) state, "mental health consumers have argued that personal growth, including taking on new activities and responsibilities, promotes recovery and contributes to the development of a full life, even when such opportunities may increase the risk of stress-related relapse" (p. 1431). Historically, clinicians have perceived individuals with SMI as having highly limited capabilities, holding deep skepticism about their abilities to live independently, work, or recover. Given these views, clinicians tend to be highly risk-averse and have employed strategies that encourage consumers to be similarly tentative about taking chances. Tolerating any risk is all-too-often conceptualized by clinicians as "setting individuals up to fail,"[4] and persons with SMI may have internalized these beliefs as well. Further, despite the positive advancements reflected in the literature on consumer growth and risk, it continues to conceptualize risk as primarily related to mental health relapse, precluding discussion of the other types of vulnerabilities and harms that the negative consequences of risk-taking can produce (Davidson, Stayner et al., 2001; Young, Green, & Estroff, 2008). Similarly, while recognizing that "risk-taking requires either confidence or faith in oneself," (Davidson, Stayner et al., 2001, p.384), the existing literature

[4] The use of this phrase by clinicians has been repeatedly documented in site visits of programs for studies examining how service providers make decisions regarding the housing and services offered to persons with SMI.

routinely fails to address the factors external to the person that influence how individuals with SMI might weigh risks vs. benefits.

If we are to encourage and support individuals with SMI to pursue social connectedness, both clinicians and consumers would need to develop "a healthy balance between personal growth and risk" (Young et al., 2008, 1434). As noted, individuals' perceptions of environmental threats may represent accurate readings of social conditions or relationships. However, they may also reflect misperceptions due to having developed maladaptive schemas in response to a history of exposure to stress and victimization (Young, Klosko, & Weishaar, 2003). These maladaptive schemas would leave them more prone to misidentify or misinterpret social cues or events as potential stressors, and to be more mistrustful of others. Assisting individuals to resolve past traumas and to identify these maladaptive schemas may lessen the degree to which situations are perceived as potentially harmful.

If, however, individuals' perceptions reflect the reality of their daily conditions fairly accurately, interventions will also need to focus on how exposure to such stressors is structured as well as how the relative weight of risks vs. benefits might be tilted more positively such that potential negative effects might be buffered. To the degree that individuals with SMI have developed a sense of powerlessness, it is critical to increase their self-efficacy and mastery. Perceptions of control and mastery may be especially critical for persons with SMI who have been victimized, since empowerment has been found to be related to quality of life for this group (Mushkatel et al., 2009). Building these internal coping resources may increase individuals' confidence for handling stress as well as for being able to enact strategies other than social withdrawal for managing risk. For some, connecting with aspects of their past may lead to greater belonging and social involvement, but may simultaneously lead to, among other things,

exposure to relapse triggers. At these junctures, greater control and empowerment may lead to more effective boundary management that harnesses the benefits of interactions while minimizing their potentially harmful impacts. Such social practice relates more to self-efficacy, assertiveness, and negotiation abilities and less to traditional social skills training that emphasizes interactional aspects such as maintaining eye contact or timing responses appropriately.

Study findings also suggest that access to socially valued roles, such as employment and opportunities to take care of others, as well as involvement in creative/artistic pursuits, fosters both self-efficacy and positive relationships. Given individuals' involvement with their children, parenting groups could be a necessary resource for building skills in this area as well. In general, clinicians will also need to become more accepting of risk and of embodying a role that encourages consumer growth while also providing the best possible safety net were individuals to fail.

Managing risk-taking (and related to creating a safety net) will also mean acknowledging the other very tangible ways in which consumers' resources and well-being can be affected when the pursuit of social connectedness exposes individuals' vulnerabilities. Living in poverty and having very limited material resources leaves individuals highly vulnerable to the negative effects of life events (McLeod & Nonemaker, 1999). Alleviating this vulnerability would mean advocating for disability policies that raise individuals' out of deep poverty and make daily survival less tenuous. Facilitating access to employment that yields sufficient incomes would also help preserve basic necessities and lessen the potential impact of negative life events. If the negative consequences of social relationships did not affect individuals' fundamental resources for survival, connectedness may be perceived as less of a threat.

Alleviating poverty would also mitigate the degree to which financial resources directly limited individuals' capacity to maintain and expand social connections. While it may be the case that

> The process of moving from recipient to peer, from charity case to contributing member of society, from hopeless to hopeful, can begin at the very basic level of mundane acts like sharing lunch with a friend, going out to a movie, or buying a present for a loved one (Davidson, Stayner et al., 2001, 386),

these mundane acts require financial resources that many individuals with SMI do not have. These social activities were described as not only essential for building connectedness, but also for reinforcing a basic sense of personhood. Without adequate incomes, the only way to participate in these mundane acts was to sacrifice other essential personal needs. Having sufficient finances would increase individuals' abilities to engage in social activities with network members, as well as increase the chances of fortuitous encounters that could develop into meaningful social connections. Similar to the ways in which Small (2009) found that childcare centers could facilitate access to social capital and social networks for parents, persons with SMI could potentially benefit from greater connections to mainstream organizations and institutions that could positively influence their social capital and network development.

Beyond individual resources, several themes spoke to participants restricting their geographic mobility, and by extension, the opportunities they may have for social affiliation and meaningful activity (Wilton, 2003). The importance of developing a sense of belonging and the potential facilitative role of being close to familiar surroundings suggest the need to more closely honor consumer choice in housing in order to address this challenge. Indeed, housing choice is positively associated with residential satisfaction and stability, as well as community adaptation (Nelson et al., 2007; Srebnik, Livingston, Gordon, & King, 1995). Choice may be especially important for individuals with SMI who are living more independently because of its positive

influence on quality of life for this group (Mushkatel et al., 2009). Maximizing housing choice may maximize the potential sense of fit and belonging that individuals with SMI experience in their neighborhoods and sets a context for broader integration. Developing distal supports in a community can also help foster a sense of belonging and routine, further contributing to individuals' ontological security (Padgett, 2007). Having this fundamental sense of stability may provide individuals with a secure base from which to launch efforts towards greater social integration.

Unfortunately, affordable housing tends to be located in more disadvantaged areas, restricting individuals' housing options and exposing them to neighborhoods of concentrated poverty and greater illicit activity. When persons with mental illness experience geographic isolation or neighborhood difficulties, service providers must explore other areas where individuals feel comfortable, and work to eliminate barriers to traveling outside the neighborhood of residence. For people in general, neighborhoods of residence no longer serve as their locus of social activity (Wellman, 2005) and providers may need to help minimize the burdens associated with traveling around.

Given widespread stigma and participants' motivation to counteract it, greater involvement in advocacy activities could also expand the networks of individuals with SMI and connect them to mainstream institutions (Frese &Walker, 1997). Further, given multiple marginalized identities, such as being LGBT, connections to support services, advocacy organizations, or community groups organized around these other identities could be helpful as well. Finally, integrated care initiatives that are designed to address multiple comorbidities and that are tailored to meet the needs of individuals who are typically not well-served by standard clinic-based care may also help prevent or reduce the negative impact of physical health

problems on connectedness (Henwood, Weinstein, & Tsemberis, 2011). Similarly, lifestyle interventions that are tailored to populations with SMI may also help reduce modifiable risk factors for poor health, such as obesity (Cabassa, Ezell, & Lewis-Fernandez, 2010).

Overall, many of these findings suggest several social and economic factors that systematically hinder individuals' full participation in society, constituting a form of 'structural violence' against persons with mental illness (Kelly, 2005). As such, instituting policies that maintain the affordability of existing housing, stimulate the creation of new affordable housing, alleviate poverty, and address issues of stigma and residential segregation are likely needed to impact the social relationships and quality of life of persons with mental illness. Nevertheless, several of the findings also relate to program features and underscore important principles of Housing First in providing a context for potentially improved social connectedness. Housing First has been associated with greater consumer choice, which positively impacts mastery (Greenwood et al., 2005), and normalized housing arrangements (i.e., apartments) have been associated with greater perceptions of choice and control compared with more supervised or congregate housing types (Nelson et al., 2007; Nelson, Hall, Walsh-Bowers, 1999; Tsemberis, Rogers, Rodis, Dushuttle, & Skryha , 2003). In Housing First, choice includes "the right to risk" and the "dignity of failure" (e.g., fostering individual agency and viewing failures as learning opportunities), potentially reducing programmatic influences on individuals with SMI being risk-averse (Tsemberis, 2010). Greater perceived choice and control may also contribute to greater internal coping resources. Housing First programs can also accommodate clients' changing preferences, and by offering scatter-site housing, they can move clients and more easily remedy situations where individuals perceive a lack of fit in their buildings or neighborhoods. Residing

in normalized housing also appeared to lessen the impact of stigma by allowing individuals to assert their identities as tenants with a rightful place in the community.

In contrast, by virtue of the supervised and congregate nature of traditional residential programs, clients are less free to make decisions and often find themselves exposed to precisely those networks of associations that can lead to strained relationships. In these programs, individuals with SMI typically associate with other residents (Aubry & Myner, 1996) who possess few financial resources (exposing them to potential requests for money), are diagnosed with mental illness (exposing them to potential stigma by group association), and have histories of alcohol or substance use (exposing them to potential relapse triggers). Additionally, such programs often limit the ability of clients to act on their desires for greater social affiliation. For example, lack of privacy hinders intimacy and lack of choice in residential location can inhibit maintaining connections with one's past. While traditional programs afford clients the valued opportunity to associate with similar others and to have a sense of belonging, these same benefits limit opportunities for activities and interactions outside the program (Browne & Courtney 2004; Browne & Courtney, 2005; Dorvil, Morin, Beaulieu, & Robert, 2005). Wright and colleagues (2007) similarly report that structural discrimination within the residential treatment system leads to sexual isolation for persons with mental illness, particularly because this system largely determined where, when, and to whom clients had access as potential partners. While the Housing First approach eliminates some of these programmatic barriers to social affiliation, a legacy of negative experiences and larger upstream factors still constrain the range of affiliations and social behaviors from which consumers can choose.

Limitations

Several limitations to the study may be noted. One set of objections may be raised as to whether participants' statements should be considered relevant or believable. These criticisms include 1) people in general may not be reliable or valid sources of information when it comes to explaining their actions or reporting on their environment, 2) persons with SMI specifically may have particularly skewed perceptions of reality and may thus be even less reliable or valid informants, and 3) people may be inclined to present themselves in a more favorable light when discussing their reasoning and courses of action, i.e., social desirability bias. Several arguments can be used to counter these suppositions or to explain how they were minimized in this project.

First, the belief that individuals are not valid or reliable sources of information has been a long-standing critique of much qualitative research. While individuals may not always provide the most accurate descriptions of their circumstances or may not correctly identify their motivations for engaging in certain activities, their subjective experiences are critically important to understanding the choices they make. Positivist assumptions about the necessity for objectivity obscure the imperative to derive experiences and understandings that are personally meaningful to participants in research. As Strauss explains (1989), qualitative research involves viewing an individual as "a person who is goal-directed, a person whose feelings and interpretation influence actions" (p.185). Thus, within Archer's framework, participants' accounts can be seen as shedding light on how participants work with the various powers and properties at play – both personal and structural – that, in this case, impact beliefs and actions relevant to social connectedness. The various factors that may influence connectedness represent a complex scenario, but this is the type of complexity for which qualitative research is well-suited. Specifically, it can uncover issues important to participants from their perspective (Buston, Parry-Jones, Livingston, Bogan, & Wood, 1998).

Second, since severe mental illness is almost by definition characterized by disordered thought processes, distorted perceptions, and other cognitive or behavioral impairments, critics may contend that reports offered by persons with severe mental illness are reflective more of the illness and not of the person's actual experiences. As Davidson (2003) observes, interviewing persons who have severe mental illness is largely equated to "conducting qualitative research with people presumed to be less articulate, less verbal, and less socialized than almost any other adults" (p.9). While persons with severe mental illness may indeed experience distortions of thought or perception, these distortions are rarely so dominant that they infuse all aspects of a participant's life. For example, an individual may have a long-standing delusion about the government owing her large sums of money, but this may not impact on her ability to report whether or not she talks with her family or knows of a park in her neighborhood. Further, individuals may at times experience active symptoms, while being largely symptom free at others. Thus, interviews with participants are not expected to be automatically irrational or nonsensical. In fact, a particular strength of the current dataset is the internal coherence of the interviews both within participant's individual reports and across participant interviews. Many of the situations and actions discussed by participants are readily understandable and make sense intuitively (e.g., perceiving the neighborhood as unsafe leading a participant to spend time at home to avoid potential danger). Beyond this internal coherence, participants' statements often echo previous research and extant knowledge in the topic area (Ware et al., 1992; Alverson, Alverson, & Drake, 2001). In a study of homeless individuals with SMI transitioning to permanent housing, Ware and colleagues (1992) found that constant exposure to others during homelessness made individuals relish and seek out any possibility for privacy and anonymity. They highlight how, "even the large amounts of time individuals spend in their rooms makes

sense in light of the privacy these newfound 'four walls' accord" (Ware et al., 1992, p.304). The chronicity of homelessness in this sample may partially account for the fact that this desire to be alone is still present among individuals with SMI several year after obtaining housing. Other findings also resonate with studies of non-homeless persons without psychiatric diagnoses. For example, participants' reported experiences of staying home to avoid dangers in their neighborhoods are consistent with findings of other studies researching the lives of individuals of similar socioeconomic backgrounds, but without SMI (Wilson, 1996). Similarities to reports likes this help corroborate the assertion that perceiving social conditions which can lead to avoidance behaviors are not imagined or unique to persons with SMI.

With participants' own accounts as the only data, the analysis may often rest on taking their responses, which may focus on proximal or otherwise personally-salient causes of distancing, at face value. While participants' "stories" may overlook historical or other contextual information that interviews with collaterals or ethnographic observations may reveal, they still have important implications for individuals' behavior and clinical practice (Alverson, Drake, Carpenter-Song, Chu, Ritsema, & Smith, 2007). This study begins to capture the multiple perspectives on distancing and affiliation as understood by participants, asking them to reflect on their social relationships and how they currently see themselves on the social spectrum.

Finally, to address the third critique, it is important to emphasize two facets of the project that help to minimize social desirability bias. First, participants were recruited from a program which emphasizes consumer voice and choice, as well as harm reduction with respect to both mental health and substance use. Because of this orientation, individuals in the program were generally encouraged to be forthright about their experiences and assured that openly discussing substance use, mental health, or housing problems would not lead to housing eviction, discharge

from the program, loss of privileges, or other reprisal. Thus, participants in this study may have felt less pressure to provide socially desirable answers, knowing that the program generally does not view problems or relapses as personal failures but as opportunities to better understand the participant and provide more helpful support. Second, most of the participants were familiar with me and other researchers within the Housing First agency, with many having been previously interviewed for other studies conducted at the program, including one that followed participants for four years. As a result of this previous work, the researchers generally enjoyed a positive reputation among participants, who often viewed the research staff as trusted confidantes. Consequently, this study benefited from the rapport and trust built with participants during earlier studies and took advantage of the personal relationships that had been maintained over time.

A second set of limitations applies to different aspects of study design. The study focused on persons in a single program type in one city and findings may vary were the study to be carried out with participants of other programs, demographic profiles, or from other regions. The study was focused on persons who have experienced homelessness and was thus overwhelmingly characterized by persons of lower SES. The sample was also mostly male and the mean age was 43; some of the findings, particularly with respect to desiring a partner and children, may reflect a desire for perceived age-appropriate life events. Since women report more negative or abusive experiences in relationships, and have often encountered separation from their children, future studies should explore how women's desires for affiliation may differ (Padgett, Hawkins, Abrams & Davis, 2006). A future study would also benefit from inclusion of a sample of participants from a wider range of SES to further uncover how a more diverse set of individuals with SMI perceives their social relationships, and whether the finding here that there may be

pathways through which SES and requisite social conditions influence social connectedness holds true. Additionally, analysis occurred subsequent to baseline data collection making it impossible to tailor interviews to explore preliminary themes more in-depth at baseline, as is the practice when using a grounded theory approach. However, the analysis of content from baseline interviews was used to tailor the follow-up interview guide.

Finally, a significant portion of the sample – who generally left or was discharged from the program under negative circumstances - could not be located to complete the follow-up interview. A quarter of the participants lost to follow-up were deceased and another quarter had entered institutions (e.g., long-term hospitalization, jail/prison) greatly contributing to the difficulty of achieving a high follow-up interview rate. It is possible that the individuals who did not complete follow-ups could have provided additional critical insights into social connectedness and whether and how it may have contributed to departures from the program. While the presence of elements of social distancing was fairly consistent across the sample at baseline, those who were no longer in the program may have developed different patterns of social behavior over time. The circumstances that led to participants' discharge both support aspects of the study's findings, as well as highlight the ways in which the findings are constrained. Problematic social relationships were directly implicated in the housing loss and, subsequent discharge, of at least four of the eight participants who did not complete follow-up interviews. This reinforces the finding that social connectedness can jeopardize housing stability. However, because these participants were not followed-up on, it is unclear how they may have assessed their social situations differently and whether they abandoned social distancing or utilized ineffective distancing strategies. Nevertheless, the interviews that are available indicate that the tension between self-preservation and social connectedness is often an on-going struggle,

and that, at times, the need for social connectedness outweighs (or overshadows) concerns regarding potential negative consequences, or, alternatively that individual efforts often fail to prevent victimization. Achieving high retention rates in multi-year follow-up studies with populations of individuals who have experienced SMI, substance abuse, and homelessness is challenging and generally results in project period of short follow-up (e.g., one to two years). Within projects utilizing interviews of participants in Housing First, the longest period of follow-up prior to this study was four years (Padgett, Gulcur, & Temberis, 2006; Stefancic & Tsemberis, 2007). Given that frequent contact at regular intervals has been credited with improved retention, future longitudinal studies of similar population would need to build in brief check-in interviews in order to maximize follow-up rates (Stefancic, Schaefer-McDaniel, Davis, & Tsemberis, 2004).

Conclusion

For this group of formerly homeless persons with SMI, appreciation for solitude and engaging in social distancing appeared to have developed in reaction to a history of exposure to relationships that involved negative interactions, stress, and threats to personal freedom, resources, and recovery (cf. Padgett et al., 2008). Simultaneously, however, individuals also desired greater social connectedness, citing a need for relationships characterized by trust, intimacy, and reciprocity. They were caught in a dilemma where desires to be less alone had to be weighed against the potential risks of engaging in social relationships: choosing to isolate meant losing access to the numerous benefits that accrue from social connectedness; however, choosing to integrate meant risking the ability to meet basic needs. This study suggests that social isolation among formerly homeless persons with SMI often reflected a lack of perceived opportunities for safe, stress-free, and supportive social affiliations, an issue that may be more a

consequence of cumulative and concentrated disadvantage than a direct effect of mental illness (Draine, Salzer, Culhane, & Hadley, 2002).

Given that support, encouragement, and acceptance from close others are considered critical to recovery, both in terms of mental illness and substance use (Davidson et al., 2001; Drake, Wallach, & McGovern, 2005), it is fairly disheartening that over the course of eight years, the social connectedness of these formerly homeless individuals with SMI was still generally low. Nevertheless, this study's findings suggest potential interventions which can enhance individual competencies, inform the structure of housing and treatment programs, and transform social policies so as to facilitate and expand opportunities and choices with respect to social affiliation. Such interventions are very much in line with a capabilities approach to social integration, which emphasizes how individual competencies, resources, and the socio-cultural environment interact to constrain or enable the actual opportunities available to individuals for establishing interpersonal connectedness and participating fully in society (Hopper, 2007; Ware et al., 2007). Given the benefits to quality of life that persons with mental illness derive from having their own homes through Housing First programs (Padgett, 2007; Yanos et al., 2004), addressing the broader factors that influence social isolation would help increase social connectedness and further enhance the effectiveness of this program model.

REFERENCES

ACLU. (2013). *The War on Marijuana in Black and White: Billions of Dollars Wasted on Racially Biased Arrests*. Retrieved from http://www.aclu.org/files/assets/aclu-thewaronmarijuana-rel2.pdf

Albert, M., Becker, T., Mccrone, P., & Thornicroft, G. (1998). Social networks and mental health service utilisation-a literature review. *International Journal of Social Psychiatry*, 44(4), 248-266.

Allen, M. (2003). Waking Rip van Winkle: Why developments in the last 20 years should teach the mental health system not to use housing as a tool of coercion. *Behavioral Sciences and the Law*, 21, 503-521.

Altschuler, A., Somkin, C. P., & Adler, N. E. (2004). Local services and amenities, neighborhood social capital, and health. *Social Science & Medicine*, 59(6), 1219-1229.

Alverson, H., Alverson, M., & Drake, R. E. (2001). Social patterns of substance use among people with dual diagnoses. *Mental Health Services Research*, 3 (1), 3-14.

Alverson, H. S., Drake, R. E., Carpenter-Song, E., Chu, E., Ritsema, M. & Smith, B. (2007). Ethnocultural variations in mental illness discourse: some implications for building therapeutic alliances. *Psychiatric Services*, 58 (12), 1541-1546.

Aneshensel, C. S., Pearlin, L. I., Mullan, J. T., Zarit, S. H., & Whitlatch, C. J. (1995). *Profiles in Caregiving: The Unexpected Career*. Academic Press.

Angell, B. (2003). Contexts of social relationship development among assertive community treatment clients. *Mental Health Services Research*, 5(1), 13–25.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal, 16*(4), 11-23

Anthony, W. A., Cohen, M. R., Farkas, M. D., & Gagne, C. (2002). *Psychiatric rehabilitation*. Boston, MA: Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University.

Archer, M. (2003). *Structure, Agency and the Internal Conversation*. Cambridge University Press: Cambridge.

Aubry, T., & Myner, J. (1996). Community integration and quality of life: A comparisons of persons with psychiatric disabilities in housing programs and community residents who are neighbors. *Canadian Journal of Community Mental Health*, 15(1), 5-20.

Baker, F., Jodrey, D., Intagliata, J., & Straus, H. (1993). Community support services and

functioning of the seriously mentally ill. *Community Mental Health Journal*, 29(4), 321–331.

Bartlett, D., & Payne, S. (1997). Grounded theory: Its basis, rationale and procedures. In G. McKenzie, J. Powell & R. Usher (Eds.), *Understanding Social Research : Perspectives on Methodology & Practice* (p. 173-195). London: Falmer Press.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, *117*(3), 497-529.

Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. (2000). From social integration to health: Durkheim in the new millennium. *Social Science and Medicine,* 51, 843-857.

Berkman, L. F., & Syme, S. L. (1979). Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. *American journal of Epidemiology*, *109*(2), 186-204.

Blankertz, L. E., & Cnaan, R. A. (1994). Assessing the impact of two residential programs for dually diagnosed homeless individuals. *Social Service Review,* 68, 536-560.

Bowen, G. A. (2006). Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods*, *5* (3), 12-23.

Bowlby, J. (1982). Attachment and loss: retrospect and prospect. *American Journal of Orthopsychiatry*, 52(4), 664–678.

Boyatzis, R. E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, CA: SAGE.

Boydell, K., Gladstone, B. M., & Crawford, E. S. (2002). The dialectic of friendship for people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 26(2), 123-31.

Browne, G & Courtney, M. (2004). Measuring the impact of housing on people with schizophrenia. *Nursing and Health Sciences*, 6(1), 37-44.

Browne, G. & Courtney, M. (2005). Housing, social support, and people with schizophrenia: a grounded theory study. *Psychosocial Rehabilitation Journal*, 20, 59-63.

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness*, 4(2), 167-182.

Buston, K., Parry-Jones, W., Livingston, M., Bogan, A., Wood, S. (1998). Qualitative research. *British Journal of Psychiatry* 172:197–199.

Byrne, T., Bettger, J. P., Brusilovskiy, E., Wong, Y. L. I., Metraux, S., & Salzer, M. S. (2013). Comparing neighborhoods of adults with serious mental illness and of the general population: Research implications. *Psychiatric Services*, 64(8), 782-788.

Cabassa, L.J., Ezell, & Lewis-Fernandez, R. (2010) Lifestyle interventions for adults with serious mental illness: a systematic literature review. *Psychiatric Services*, 61(8): 774—82.

Caron, J., Tempier, R., Mercier, C., & Leouffre, P. (1998). Components of social support and quality of life in severely mentally ill, low income individuals and a general population group. *Community Mental Health Journal*, 34(5), 459–475.

Caton, C. L., Shrout, P. E., Dominguez, B., Eagle, P. F., Opler, L. A., & Cournos, F. (1995). Risk factors for homelessness among women with schizophrenia. *American Journal of Public Health*, 85(8_Pt_1), 1153-1156.

Caughy, M. O. B., O'Campo, P. J., & Muntaner, C. (2003). When being alone might be better: neighborhood poverty, social capital, and child mental health. *Social Science & Medicine*, 57(2), 227-237.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage.

Cockerham, W. C. (2005). Health lifestyle theory and the convergence of agency and structure. *Journal of Health and Social Behavior*, 46, 51-67.

Colton, C. W., & Manderscheid, R. W. (2006). Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. *Preventing Chronic Disease*, 3(2).

Cornwell, B., Laumann, E. O., & Schumm, L. P. (2008). The social connectedness of older adults: A national profile. *American Sociological Review*, 73(2), 185-203.

Corin, E., & Lauzon, G. (1992). Positive withdrawal and the quest for meaning: The reconstruction of experience among schizophrenics. *Psychiatry: Journal for the Study of Interpersonal Processes, 55,* 266–278.

Cornwell, E. Y. & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior*, 50 (1), 31-48.

Corrigan, P. W., & Phelan, S. M. (2004). Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal*, 40 (6), 513–523.

Cosden, M., Ellens, J., Schnell, J., Yamini-Diouf, Y. (2005) Efficacy of a Mental Health Treatment Court with Assertive Community Treatment. *Behavioral Sciences and the Law*, 23, 199-214.

Dailey, W. F., Chinman, M. J., Davidson, L., Garner, L., Vavrousek-Jakuba, E., Essock, S., et al. (2000). How are we doing? A statewide survey of community adjustment among people with serious mental illness receiving intensive outpatient services. *Community Mental Health Journal*, 36(4), 363–382.

Davidson L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: New York University Press.

Davidson, L., Haglund, K. E., Stayner, D. A., Rakfeldt, J., Chinman, M. J., & Kraemer Tebes, J. (2001). 'It was just realizing...that life isn't one big horror': A qualitative study of supported socialization. *Psychiatric Rehabilitation Journal*, 24(3), 275–292.

Davidson, L., & Stayner, D. (1997). Loss, loneliness, and the desire for love: Perspectives on the social lives of people with schizophrenia. *Psychiatric Rehabilitation Journal*, 20(3), 3–12.

Davidson, L., Stayner, D., & Haglund, K. E. (1998). Phenomenological perspectives on the social functioning of people with schizophrenia. In K. T. Mueser & N. Tarrier (Eds.), *Handbook of social functioning in schizophrenia* (pp. 97–120). Needham Heights, MA, US: Allyn & Bacon.

Davidson, L., Stayner, D. A., Nickou, C. Styron, T. H., Rowe, M., Chinman, M. L. (2001). Simply to be let in: Inclusion as a basis for recovery. *Psychiatric Rehabilitation Journal*, 24(4), 375-385.

Denzin, N. K. & Lincoln, Y. S. (Eds.) (2004). *Handbook of Qualitative Research*. London: Routledge.

Dorvil, H., Morin, P., Beaulieu, A. & Robert, D. (2005). Housing as a social integration factor for people classified as mentally ill. *Housing Studies*, 20(3), 497-519.

Draine, J., Salzer, M. S., Culhane, D. P., & Hadley, T. R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services, 53* (5), 565-573.

Drake, R. E., Wallach, M. A., & McGovern, M. P. (2005). Future directions in preventing relapse to substance abuse among clients with severe mental illnesses. *Psychiatric Services*, 56, 1297-1302.

Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Medical Care*, 49(6), 599-604.

Duffy, K. (1995), *Social Exclusion and Human Dignity in Europe*. Strasbourg: Council of Europe.

Elster, J. (1982). Sour grapes – utilitarianism and the genesis of wants, in A. Sen & B. Williams (eds.) *Utilitarianism and Beyond*. Cambridge: Cambridge University Press.

Erickson, F. (1986). Qualitative methods in research on teaching. In M. Wittrock (Ed.), Handbook of research on teaching (3rd ed., pp. 119–161). New York: Macmillan.

Evans, G. W., & English, K. (2002). The environment of poverty: Multiple stressor exposure, psychophysiological stress, and socioemotional adjustment. *Child Development*, 73(4), 1238-1248.

Feldman, L. C. (2004). *Citizens without Shelter: Homelessness, Democracy, and Political Exclusion.* Ithaca: Cornell University Press.

Ford, M.C. (2005). Frequent Fliers: The High Demand User in Local Corrections. *Californian Journal of Health Promotion*, 3 (2), 61-71.

Frese, F. J., & Davis, W. W. (1997). The consumer–survivor movement, recovery, and consumer professionals. *Professional Psychology: Research and Practice*, *28*(3), 243.

Frohlich, K. L., Corin, E., & Potvin, L. (2001). A theoretical proposal for the relationship between context and disease. *Sociology of Health & Illness*, 23 (6), 776-797.

Gans, H. J. (1990). Deconstructing the Underclass The Term's Dangers as a Planning Concept. *Journal of the American Planning Association*, 56(3), 271-277.

Giddens, A. (1990) *The Consequences of Modernity.* Stanford, CA: Stanford University Press.

Glaser, B. & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine Publishing Company.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* Englewood Cliffs, N.J.: Prentice Hall.

Goldstein, J. (2013, August 12). Judge rejects New York's stop-and-frisk policy. *The New York Times*, pA1.

Granovetter, M. (1983). The strength of weak ties: A network theory revisited. *Sociological Theory*, 1(1), 201-233.

Green, B., Miranda, J., Daroowalla, A., Siddique, J. (2005). Trauma exposure, mental health functioning and program needs of women in jail. *Crime and Delinquency Journal*, 51, 1, 133-151.

Greenwood, R., Schaefer-McDaniel, N., Winkel, G., & Tsemberis, S. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of

homelessness. *American Journal of Community Psychology*, 16, 223-238.

Grigsby, C., Baumann, D., Gregorich, S. E., & Roberts-Gray, C. (1990). Disaffiliation to entrenchment: A model for understanding homelessness. *Journal of Social Issues*, *46*(4), 141-156.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. N. (2003) Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in Continuum of Care and Housing First programmes. *Journal of Community & Applied Social Psychology*, 13, 171-186.

Hamilton, N. G., Ponzoha, C. A., Cutler, D. L., & Weigel, R. M. (1989). Social networks and negative versus positive symptoms of schizophrenia. *Schizophrenia Bulletin*, 15(4), 625.

Harding, C. (1987a). The Vermont longitudinal study of persons with mental illness I. *American Journal of Psychiatry, 144*, 718–726.

Harding, C. (1987b). The Vermont study of persons with mental illness II. American *Journal of Psychiatry, 144*, 727–735.

Harrel, A., Roman, J. (2001). Reducing drug use and crime among offenders: The impact of graduated sanctions. *Journal of Drug Issues* 31, 207–231.

Harris, T., Brown, G. W., & Robinson, R. (1999). Befriending as an intervention for chronic depression among women in an inner city. I: Randomised controlled trial. *British Journal of Psychiatry*, 174, 219–224.

Hawkins, R. & Abrams, C. (2007). The social networks of formerly homeless individuals with co-occurring disorders. *Social Science & Medicine*, 65(10), 2031-2042.

Henwood, B. F., Stefancic, A., Petering, R., Schrieber, S., Padgett, D. K., & Abrams, C. (n.d.). Social Relationships of Dual Diagnosed Homeless Adults Following Enrollment in Housing First or Traditional Treatment Services.

Henwood, B. F., Weinstein, L. C., & Tsemberis, S. (2011). Creating a medical home for homeless persons with serious mental illness. *Psychiatric Services*, 62(5), 561-562.

Hoang, U., Stewart, R., & Goldacre, M. J. (2011). Mortality after hospital discharge for people with schizophrenia or bipolar disorder: retrospective study of linked English hospital episode statistics, 1999-2006. *BMJ*, 343.

Hopper, K. (2003). *Reckoning with homelessness*. Ithaca: Cornell University Press.

Hopper, K. (2007). Rethinking social recovery in schizophrenia: what a capabilities approach might offer. *Social Science & Medicine*, 65 (5), 868-879.

Hopper, K. (2012). Commentary: The counter-reformation that failed? A commentary on the mixed legacy of supported housing. *Psychiatric Services* 63, 461-463.

House, J. S. (1987). Social support and social structure. *Sociological Forum*, 2 (1), 135-146.

House, J. S. (2001). Social isolation kills, but how and why? *Psychosomatic Medicine*. 63 (2), 273-274.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science, 241*(4865), 540-545.

House, J. S., Umberson, D., & Landis, K. R. (1988). Structures and processes of social support. Annual Review of Sociology, 293-318.

Huckfeldt, R. R. (1983). Social contexts, social networks, and urban neighborhoods: Environmental constraints on friendship choice. *American Journal of Sociology*, 89, 651-669.

Kawachi, I. & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health*, 78 (3), 458-467.

Kelly, B. D. (2005). Structural violence and schizophrenia. *Social Science & Medicine*, 61(3), 721-730.

Kilian, R., Lindenbach, I., Löbig, U., Uhle, M., Petscheleit, A., & Angermeyer, M. C. (2003). Indicators of empowerment and disempowerment in the subjective evaluation of the psychiatric treatment process by persons with severe and persistent mental illness: a qualitative and quantitative analysis. *Social Science & Medicine, 57*(6), 1127-1142.

Killeen, C. (1997). Loneliness: An epidemic in modern society. *Journal of Advanced Nursing*, 28, 762-770.

Klinenberg, E. (2003). *Heat Wave: A Social Autopsy of Disaster in Chicago*. University of Chicago Press.

Kloos, B., & Shah, S. (2009). A social ecological approach to investigating relationships between housing and adaptive functioning for persons with serious mental illness. *American Journal of Community Psychology, 44*(3-4), 316-326.

Krause, N., & Borawski-Clark, E. (1995). Social class differences in social support among older adults. *The Gerontologist*, 35, 498-508.

Krieger, N., & Davey Smith, G. (2004). "Bodies count," and body counts: social epidemiology and embodying inequality. *Epidemiologic Review*, 26), 92–103.

Krupa, T., McLean, H., Eastabrook, S., Bonham, A., & Baksh, L. (2003). Daily time use as a

measure of community adjustment for clients of assertive community treatment. *American Journal of Occupational Therapy*, 57, 558-565.

Lamberti, J. (2007) Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services*, 58 (6), 773-781.

Lamberti, J. S., Weisman, R. L., Schwarzkopf, S. B., Price, N., Ashton, R. M., & Trompeter, J. (2001). The mentally ill in jails and prisons: Towards an integrated model of prevention. *Psychiatric Quarterly*, 72, 63-77.

Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *BMJ*, 346.

LeMelle, S. & Monahan, J. (2007). Housing and use of leverage in mental health treatment. *BMC Psychiatry*, 7 (suppl 1), S27.

Lincoln, K. D. (2000). Social support, negative social interactions, and psychological well-being. *Social Service Review,* 74 (2), 231-252.

Lincoln, K. D. (2008). Personality, negative interactions, and mental health. *The Social Service Review*, 82(2), 223-251

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic Enquiry*. London: Sage.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 80-94.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology*, 363-385.

Lloyd, C., Wong, S. R., & Petchkovsky, L. (2007). Art and recovery in mental health: A qualitative investigation. *The British Journal of Occupational Therapy*, 70(5), 207-214.

Lynch, J., & Kaplan, G. (2000). Socioeconomic position. In L. F. Berkman & I. Kawachi (Eds.), *Social Epidemiology* (pp. 13–35). New York: Oxford University Press.

MacDonald, E. M., Jackson, H. J., Hayes, R. L., Baglioni, A. J., Jr., & Madden, C. (1998). Social skills as determinant of social networks and perceived social support in schizophrenia. *Schizophrenia Research*, 29 (3), 275-286.

Marmot, M. (2004). *The Status Syndrome: How Social Standing Affects Our Health and Longevity***.** Henry Holt & Co.

Marsden, P. V. (1987). Core Discussion Networks of Americans. *American Sociological Review,* 52, 122–31.

Maslow, A.H. (1943). A theory of human motivation. Psychological Review, 50: 370-396.

Mauer, M., & King, R. S. (2007). *Uneven justice: State rates of incarceration by race and ethnicity* (pp. 1-23). Washington, DC: Sentencing Project.

McLeod, J. D. & Nonemaker, J. M. (1999). Social stratification and inequality. In C. S. Aneshensel & J. C. Phelan (Eds.), *Handbook of the Sociology of Mental Health* (pp.321-344). New York: Springer

Meeks, S. & Hammond, C. T. (2001). Social network characteristics among older outpatients with long-term mental illness. *Journal of Mental Health and Aging*, 7, 445-464.

Mehta, S. & Farina, A. (1988) Associative stigma: perceptions of the difficulties of college-aged children of stigmatized fathers. *Journal of Social Clinical Psychology*, 7, 192 -202.

Metraux, S., Brusilovskiy, E., Prvu-Bettger, J. A., Irene Wong, Y. L., & Salzer, M. S. (2012). Geographic access to and availability of community resources for persons diagnosed with severe mental illness in Philadelphia, USA. *Health & Place*, 18(3), 621-629.

Meyer, I. H., & Schwartz, S. (2000). Social issues as public health: promise and peril. *American Journal of Public Health*.

Mickelson, K. D. & Kubzansky, L. D. (2003). Social distribution of social support: The mediating role of life events. *American Journal of Community Psychology*, 32, 265-281.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative Data Analysis (2nd ed.).* London: SAGE.

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage.

Miller, D. R. & Flack, W. E (1990). A socio-psychological approach to understanding schizophrenia. Paper presented at the annual convention of the American Psychological Association, Boston, MA.

Mirowsky, J. & Ross, C. E. (1983). Paranoia and the structure of powerlessness. *American Sociological Review*, 48, 228-39.

Monahan, J., Redlich, A. D., Swanson, et al.. (2005). Use of leverage to improve adherence to psychiatric treatment in the community. *Psychiatric Services*, *56*(1), 37-44.

Morabito, M. S. (2007). Horizons of context: Understanding the police decision to arrest people with mental illness. *Psychiatric Services*, 58(12), 1582-1587.

Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V. & Priebe, S. (2007).Social exclusion and

mental health: conceptual and methodological review. *British Journal of Psychiatry*, 191, 477-83.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250.

Morrow, S. L., & Smith, M. L. (1995). Constructions of survival and coping by women who have survived childhood sexual abuse. *Journal of Counseling Psychology*, 42(1), 24.

Mueser, K., Essock, S., Drake, R., Wolfe, R., & Frisman, L. (2001). Rural and urban Differences in patients with a dual diagnosis. *Schizophrenia Research*, 48(1), 93-107.

Mushkatel, A., Guhathakurta, S., Thompson, J., Thomas, K., & Franczak, M. (2009). Housing Choice, Outcomes, and Neighborhood Characteristics in Housing Programs for Individuals with a Serious Mental Illness: Analysis of a Phoenix Survey of Individuals with Serious Mental Illness. *Public Administration Quarterly*, 481-519.

Nelson, G., Hall, G. B., & Walsh-Bowers, R. (1999). Predictors of the adaptation of people with psychiatric disabilities in group homes, supportive apartments, and board-and-care homes. *Psychiatric Rehabilitation Journal*, 22(4), 381-389.

Nelson, G., Sylvestre, J. Aubry, T., George, L., & Trainor, J. (2007). Housing choice and control, housing quality, and control over professional support as contributors to the subjective quality of life and community adaptation of people with severe mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 34, 89-100.

New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America.* Pub no SMA-03-3832. Rockville, MD, US Department of Health and Human Services, New Freedom Commission on Mental Health.

Newman, S. J. (2001). Housing attributes and serious mental illness: implications for research and practice. *Psychiatric Services, 52*(10), 1309-1317.

Nussbaum, M. C. (2000a) *Women and Human Development: The Capabilities Approach*. Cambridge University Press: Cambridge.

Nussbaum, M. C. (2000b). The costs of tragedy: Some moral limits of cost-benefit analysis. The *Journal of Legal Studies*, 29(2), 1005-1036.

Olesen, V. (1994). Problematic bodies: Past, present, and future. *Symbolic Interaction*, 17, 231-237.

Orfield, M. (2011). *Metropolitics: A regional agenda for community and stability*. Washington, D.C.: Brookings Institution Press.

Padgett, D. (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. *Social Science & Medicine,* 64, 1925-1936.

Padgett, D. (2012). *Qualitative and mixed methods in public health.* Thousand Oaks, Calif.: SAGE.

Padgett, D. K., Gulcur, L., & Tsemberis, S. (2006). Housing first services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice*, 16(1), 74-83.

Padgett, D. K., Hawkins, R., Abrams, C., & Davis, A. (2006). In their own words: Trauma and substance abuse in the lives of formerly homeless women with serious mental illness. *American Journal of Orthopsychiatry, 76,* 461–467.

Padgett D. K., Henwood, B., Abrams, C. & Drake, R. (2008) Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. *American Journal of Orthopsychiatry,* 78 (3), 333-339.

Padgett, D. K., Tran Smith, B. T., Henwood, B. F., & Tiderington, E. (2012). Life course adversity in the lives of formerly homeless persons with serious mental illness: context and meaning. *American Journal of Orthopsychiatry*, 82(3), 421-430.

Padgett, D. K., & Struening, E. L. (1992). Victimization and traumatic injuries among the homeless: associations with alcohol, drug, and mental problems. *American Journal of Orthopsychiatry*, 62(4), 525.

Perese, E.F. (1997). Unmet needs of persons with chronic mental illnesses: Relationship to their adaptation to community living. *Issues in Mental Health Nursing*, 18, 19-34.

Perese, E. F. & Wolf, M. (2005). Combating loneliness among persons with severe mental illness: social network interventions' characteristics, effectiveness, and applicability. *Issues in Mental Health Nursing,* 26 (591-609).

Perry, B. L. (2014). Symptoms, stigma, or secondary social disruption? An evaluation of three mechanisms of network dynamics in severe mental illness. J*ournal of Social and Personal Relationships*, 31(1), 32-53.

Peters, R. & Murrin, M. (2000). Effectiveness of treatment-based drug courts in reducing criminal recidivism. *Criminal Justice and Behavior* 27, 72–96.

Piatt, E., Munetz, M., & Ritter, C. (2010). An examination of premature mortality among decedents with serious mental illness and those in the general population. *Psychiatric Services*, 61(7), 663-668.

Pierce, G. R., Sarason, B. R., & Sarason, I. G. (eds). (1996). *Handbook of Social Support and the Family*. Plenum Press: New York.

Rankin, J. (2005). *Mental Health in the Mainstream Working Paper Two: Mental Health and Social Inclusion.* Institute of Public Policy Research: London. Retrieved from http://www.rethink.org/document.rm?id=847.

Robilotta, S., Cueto, E., & Yanos, P. T. (2010). An examination of stress and coping among adults diagnosed with severe mental illness. *The Israel Journal of Psychiatry and Related Sciences*, 47(3), 222.

Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent supportive housing: assessing the evidence. *Psychiatric Services*, 65(3), 287-294.

Rogers, E. S., Anthony, W., & Lyass, A. (2004). The nature and dimensions of social support among individuals with severe mental illnesses. *Community Mental Health Journal*, 40(5), 437–450.

Roschelle, A. R. (1997). *No More Kin: Exploring Race, Class, and Gender in Family Networks*. Thousand Oaks, CA: Sage Publications.

Rowe, M. (1999). *Crossing the border: Encounters between homeless people and outreach workers*. Berkeley, CA: University of California Press.

Salyers, M. P. & Tsemberis, S. (2007). ACT and recovery: Integrating evidence-based practice and recovery orientation on Assertive Community Treatment teams. *Community Mental Health Journal, 43(6), 619-641.*

SAMHSA (2006). *Transforming Housing for People With Psychiatric Disabilities Report.* HHS Pub. No. 4173. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

SAMHSA (2009). Transforming Mental Health Care in America: The Federal Action Agenda: First Steps. Retrieved from http://www.samhsa.gov/federalactionagenda/NFC_FMHAA.aspx

SAMHSA (2012). *SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery.* Retrieved from http://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf

SAMHSA (2014). *National Registry of Evidence-based Program and Practices: Pathways Housing First Program*. Retrieved from http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=195

Savage, A. & Russell L., A. (2005). Tangled in a web of affiliation: Social support networks of dually diagnosed women who are trauma survivors. *Journal of Behavioral Health Services and Research*, 32 (2), 199–214.

Scott, J., & Carrington, P. J. (Eds.). (2011). *The SAGE Handbook of Social Network Analysis*. SAGE publications.

Seeman, T. E. (1996). Social ties and health: The benefits of social integration. *Annals of epidemiology*, *6*(5), 442-451.

Sen, A. (1985). *Commodities and Capabilities.* Amsterdam: North Holland.

Sen, A. (1987). The standard of living: lecture I, concepts and critiques. *The Standard of Living*, 1-19.

Shibusawa, T., & Padgett, D. (2009). The experiences of "aging" among formerly homeless adults with chronic mental illness: A qualitative study. *Journal of Aging Studies*, 23(3), 188-196.

Siegel, C. E., Samuels, J., Tang, D., Berg, I., Jones, K., & Hopper, K. (2006). Tenant outcomes in supported housing and community residences in New York City. *Psychiatric Services*, 57(7), 982-991.

Skaff, M. M., & Pearlin, L. I. (1992). Caregiving: Role engulfment and the loss of self. *The Gerontologist*, 32(5), 656-664.

Skeem, J. L., & Louden, J. E. (2006). Toward evidence-based practice for probationers and parolees mandated to mental health treatment. *Psychiatric Services*, *57*(3), 333-342.

Small, M. (2009). Unanticipated Gains: Origins of Network Inequality in Everyday Life. New York: Oxford University Press.

Snow, D. A. & Anderson, L. (1993). *Down on Their Luck: A Study of Homeless Street People*. Berkeley: University of California Press.

Spaniol, L., Bellingham, R., & Cohen, B., (2003). *The recovery workbook: II. Connectedness.* Boston: Boston University Center for Psychiatric Rehabilitation.

Spencer, M. B. (2001). Resiliency and fragility factors associated with the contextual experiences of low-resource urban African-American male youth and families. In A. Booth & A. C. Crouter (eds.), *Does It Take A Village?* (pp.51-77). Mahwah, NJ: Lawrence Erlbaum Associates.

Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal, 31*(2), 139-152.

Stefancic, A., Schaefer-McDaniel, N. J., Davis, A. C., & Tsemberis, S. (2004). Maximizing

follow-up of adults with histories of homelessness and psychiatric disabilities. *Evaluation and Program Planning*, 27(4), 433-442.

Stefancic, A. & Tsemberis, S. (2007) Housing First for long-term shelter dwellers with psychiatric disabilities in a suburban county: a four-year study of housing access and retention. *Journal of Primary Prevention*, 28(3-4), 265-279.

Stefancic, A., Tsemberis, S., Messeri, P., Drake, R., & Goering, P. (2013). The Pathways Housing First fidelity scale for individuals with psychiatric disabilities. *American Journal of Psychiatric Rehabilitation*, 16(4), 240-261.

Stephen J. (2001). *Census of Jails, 1999*. Pub no NCJ 18663. Washington, DC, US Department of Justice Programs, Bureau of Justice Statistics.

Strauss, A. (1989). Subjective experiences of schizophrenia: Toward a new dynamic psychiatry: II. *Schizophrenia Bulletin*, 15 (2), 179-187.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications, Inc.

Strauss, J. S.,Hafez,H., Leiberman, P., & Harding, C. M. (1985). The course of psychiatric disorder: three longitudinal principles. *American Journal of Psychiatry*, 142, 289-296.

Sundeen, S. (2000). Psychiatric rehabilitation. In G. Stuart & M. Laraia (Eds.), *Principles and Practice of Psychiatric Nursing* (pp.246-264). St. Louis, MO: Mosby.

Teplin, L. A., McClelland, G. M., Abram, K. A., & Weiner, D. A. (2005). Crime victimization in adults with severe mental illness: comparison with the National Crime Victimization Survey. *Archives of General Psychiatry*, 62(8), 911-921.

Thompson. K. S. & Rowe, M. (2010). Social inclusion. *Psychiatric Services*, 61 (8), 735.

Thoits, P. A. (1999). Self, identity, stress, and mental health. In C. S. Aneshensel & J. C. Phelan (Eds.), *Handbook of the sociology of mental health* (pp. 345-368). New York: KluwerAcademic/Plenum.

Tigges, L. M., Browne, I., & Green, G. P. (1998). Social isolation of the urban poor: Race, class, and neighborhood effects on social resources. *Sociological Quarterly*, *39*(1), 53-77.

Toohey, S. M., Shinn, M., & Weitzman, B.C. (2004). Social networks and homelessness among women heads of household. *American Journal of Community Psychology*, 33, 7-20.

Townley, G., Miller, H., & Kloos, B. (2013). A Little Goes a Long Way: The Impact of Distal Social Support on Community Integration and Recovery of Individuals with Psychiatric Disabilities. *American Journal of Community Psychology*, 52(1-2), 84-96.

Townsend, A. L., Biegel, D. E., Ishler, K. J., Wieder, B., & Rini, A. (2006). Families of persons with substance use and mental disorders: A literature review and conceptual framework. *Family Relations,* 55, 473–486.

Tsai, J., Mares, A. S., & Rosenheck, R. A. (2012). Does housing chronically homeless adults lead to social integration?. *Psychiatric Services*, 63(5), 427-434.

Tsemberis, S. (2010). *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*. Center City: Hazelden.

Tsemberis, S., & Asmussen, S. (1999). From streets to homes: The Pathways to Housing consumer preference supported housing model. *Alcoholism Treatment Quarterly*, 17(1-2), 113-131.

Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing First, consumer choice and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.

Tsemberis, S., Rogers, E. S., Rodis, E., Dushuttle, P., & Skryha, V. (2003). Housing satisfaction for persons with psychiatric disabilities. *Journal of Community Psychology*, 31(6), 581-590.

Turner, R. J. & Turner, J. B. (1999). Social integration and support. In C. S. Aneshensel & J. C. Phelan (Eds.), *The Handbook of the Sociology of Mental Health* (pp. 301-319). New York: Kluwer.

Ware, N. C., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2007). Connectedness and citizenship: redefining social integration. *Psychiatric Services,* 58, 469-474.

Umberson, D., & Montez, J. K. (2010). Social relationships and health a flashpoint for health policy. *Journal of Health and Social Behavior*, 51(1 suppl), S54-S66.

Ware, N. C., Desjarlais, R. R., AvRuskin, T. L., Breslau, J., Good, B. J., & Goldfinger, S. M. (1992). Empowerment and the transition to housing for homeless mentally ill people: An anthropological perspective. *New England Journal of Public Policy*, 8(1), 26.

Ware, N., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2008). A theory of social integration as quality of life. *Psychiatric Services, 59,* 27–33.

Weiner, A., Roe, D., Mashiach-Eizenberg, M., Baloush-Kleinman, V., Maoz, H., & Yanos, P. T. (2010). Housing model for persons with serious mental illness moderates the relation between loneliness and quality of life. *Community Mental Health Journal*, 46(4), 389-397.

Wellman, B. (1979). The community question. *American Journal of Sociology* 84, 1201-31.

Wellman, B. (2005). Community: from neighborhood to network. Communications of the ACM,

48(10), 53-55.

Whitley, R. (2011). Social defeat or social resistance? Reaction to fear of crime and violence among people with severe mental illness living in urban 'recovery communities'. *Culture, Medicine, and Psychiatry*, 35(4), 519-535.

Whitley, R., & Prince, M. (2005). Fear of crime, mobility and mental health in inner-city London, UK. *Social Science & Medicine*, 61(8), 1678-1688.

Wieland, M. E., Rosenstock, J., Kelsey, S. F., Ganguli, M., & Wisniewski, S. R. (2007). Distal support and community living among individuals diagnosed with schizophrenia and schizoaffective disorder. *Psychiatry: Interpersonal and Biological Processes*, 70(1), 1-11.

Williams, G. H. (2003). The determinants of health: structure, context and agency. *Sociology of Health & Illness*, 25(3), 131-154.

Williams, G.H., Popay, J. & Bissell, P. (1995) Public health risks in the material world: barriers to social movements in health. In J.Gabe (ed) *Medicine, Health, and Risk* (Sociology of Health and Illness Monograph Series). Oxford: Blackwell.

Wilson, W. J. (1996) *When Work Disappears: The World of the New Urban Poor.* New York: Knopf.

Wilton, R. D. (2003). Poverty and mental health: a qualitative study of residential care facility tenants. *Community Mental Health Journal*, 39 (2), 139-156.

Wilton, R. (2004). Poverty and people with serious mental illness: Putting policy into practice? *Social Science & Medicine*, 58, 25-39.

Wolf, J., Burnam, A., Koegel, P., Sullivan, G., & Morton, S. (2001). Changes in subjective quality of life among homeless adults who obtain housing: a prospective examination. *Social Psychiatry and Psychiatric Epidemiology*, 36(8), 391-398.

Wong, Y. L. I., & Solomon, P. L. (2002). Community integration of persons with psychiatric disabilities in supportive independent housing: A conceptual model and methodological considerations. *Mental Health Services Research*, 4(1), 13-28.

Wright, E. R., Wright, D. E., Perry, B. L., & Foote-Ardah, C. (2007). Stigma and the sexual isolation of people with serious mental illness. *Social Problems*, 54(4), 78-98.

Yanos, P., Barrow, S. & Tsemberis, S. (2004). Community Integration in the Early Phase of Housing Among Homeless Persons Diagnosed with Severe Mental Illness: Successes and Challenges. *Community Mental Health Journal*, 40 (2), 133-150.

Yanos, P. T., Felton, B., Tsemberis, S., & Frye, V. A. (2007). Exploring the role of housing type,

neighborhood characteristics, and lifestyle factors in the community integration of formerly homeless persons diagnosed with mental illness. *Journal of Mental Health*, 16(6), 703-717.

Yanos, P. T., & Robilotta, S. (2011). An Examination of Time-Use among Adults Diagnosed with Severe Mental Illness using Daily Interviews. *Psychiatric Rehabilitation Journal*, 34, 243-247.

Yanos, P. T., Rosenfeld, S., & Horowitz, A. V. (2001). Negative and supportive social interactions and quality of life among persons diagnosed with severe mental illness. *Community Mental Health Journal*, 37, 405-419.

Yanos, P. T., Stefancic, A., & Tsemberis, S. (2012). Objective Community Integration of Mental Health Consumers Living in Supported Housing and Other Community Members. *Psychiatric Services*, 63, 438-444.

Young, A., Green, C., & Estroff, S. (2008). New endeavors, risk taking, and personal growth in the recovery process: findings from the STARS study. *Psychiatric Services*, 59(12), 1430-1436.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema Therapy: A Practitioner's Guide*. Guilford Press.