American Journal of Orthopsychiatry
2008, Vol. 78, No. 3, 333–339

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0002-9432/08/$12.00 DOI: 10.1037/a0014155

Social Relationships Among Persons Who Have Experienced Serious Mental Illness, Substance Abuse, and Homelessness: Implications for Recovery

Deborah K. Padgett, PhD, Ben Henwood, LCSW, and Courtney Abrams, MA
New York University

Robert E. Drake, MD, PhD
Dartmouth Medical School

The new paradigm of recovery has highlighted the importance of positive social relationships, but little is known about their role in recovery among homeless individuals with serious mental illness and comorbid substance abuse. This study used within- and across-case analyses of longitudinal data from qualitative interviews with 41 dually diagnosed individuals entering residential programs to exit homelessness and receive needed services. Thematic findings include (a) "loner talk" and the need for privacy; (b) family ties as "good news, bad news"; (c) when it comes to a partner, other things come first; and (d) in search of positive people. Analyses of change in individual trajectories revealed that stronger social relationships did not coincide exactly with positive outcomes. Although positive life changes were gradual, negative changes could be precipitous. Social relationships were threatened by concentrated disadvantage, that is, a lack of social and economic currency. Findings are discussed with implications for improving services for the most vulnerable individuals who stand to benefit from the era of recovery.

Keywords: serious mental illness, substance abuse, social relationships, recovery

Several decades after deinstitutionalization, social isolation is viewed as a significant problem for persons with serious mental illness (Davidson et al., 2001;Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007). A number of factors have been identified as contributing to isolation, including personal attributes (fear of victimization, odd behavior, and underdeveloped social skills) and larger societal forces (stigma and negative stereotyping; Davidson et al., 2001; Phelan & Link, 2004; Scheff, 1966). People with serious mental illness are said to lack social currency, that is, the personal attributes and resources that spark others' interest in connecting with them (Ware et al., 2007). High unemployment, periodic institutionalizations, and living in disadvantaged neighborhoods further reduce opportunities to engage in reciprocal social activities (Morgan, Burns, Fitzpatrick, Pinfold & Priebe, 2007).

Social isolation may be offset by unstable social affiliations when mentally ill people are also homeless and abuse substances (Alverson, Alverson, & Drake, 2000; Todd et al., 2004). Drug abuse, for example, may bring "friends" in fellow users (Alverson et al., 2000; Drake, Wallach, Alverson, & Mueser, 2002), and homelessness, although deeply isolating, can lead to bonding with others in shelters or encampments (Dordick,1996; Hopper, 2003).

Although the new paradigm of mental health recovery highlights the importance of positive, nurturing social ties (Alverson et al., 2000; Anthony, 1993; Breier & Strauss, 1984; Spaniol, Bellingham, & Cohen, 2003), the individual must enact his or her own recovery (Deegan & Drake, 2006; Jacobson & Greenley, 2001; Ridgeway, 2001). Yet most consumers, perhaps a majority, must overcome not just mental illness but some combination of substance use disorders, criminal justice entanglements, poverty, unemployment, housing problems, trauma histories, and other complications. Understandably, focusing on a positive and empowering message regarding life after (or with) serious mental illness, the recovery movement has given relatively little consideration to these complications.

Little is known about social relationships among such people and how they change over time. Given their volatility and occasionally illegal premises (e.g., drug deals), social ties can be harmful and helpful, their valence often shifting and always deeply subjective. Providers and programs have identified social isolation as the worthy target of interventions ranging from social skills training (Scott & Dixon, 1995) to supported socialization (Davidson et al., 2001). Although these interventions have yielded some positive findings, their effectiveness remains uncertain outside of controlled trials and with real-world clients who have multiple interacting problems.

This qualitative study draws on analyses of longitudinal data from in-depth interviews with 41 dually diagnosed persons enrolled in the National Institute of Mental Health–sponsored New York Services Study in 2004–2006. The goals of the New York Services Study entailed recruiting people entering residential pro-

Deborah K. Padgett, PhD, Ben Henwood, LCSW, and Courtney Abrams, MA, Silver School of Social Work, New York University; Robert E. Drake, MD, PhD, Dartmouth Psychiatric Research Center, Dartmouth Medical School.

This project was supported by Grant R01-MH69865 from the National Institute of Mental Health. We are deeply grateful to the study participants for graciously sharing their life experiences. We also want to thank New York Services Study staff members Andrew Davis, Ana Stefancic, and Rebecca Lopatin for assistance in data collection and preliminary analyses.

For reprints and correspondence: Deborah K. Padgett, PhD, Silver School of Social Work, New York University, 1 Washington Square North, New York, NY 10003. E-mail: dkp1@nyu.edu

grams to escape homelessness and gain access to needed services. In this report, we analyze study participants' social relationships over a 12-month period in the context of other aspects of their lives. Research questions include (a) what is the nature of social relationships in this population and (b) how (if at all) are social relationships related to progress in recovery over time?

Social relationships are defined as any bonds—family, friends, or others—that participants refer to as meaningful in some way (they do not need to be uniformly positive). Mental health *recovery* refers to the long-term process that involves improved hope and self-esteem and normalizing activities such as having a partner, earning a living, and being engaged in society (Deegan, 2005; Fisher, 1994; Jacobson, 2004; Ware et al., 2007; Wong & Solomon, 2002). For our study population, it presumably also means achieving some measure of residential stability and control over substance abuse, that is, *recovery* in its original connotation.

We chose qualitative case study methods as most appropriate given their emphasis on rapport and sensitivity and their capacity to preserve the dynamic, holistic nature of individual lives. Qualitative methods elicit factual information (e.g., number of children and length of hospital stay), but their strength lies in encouraging interviewees to speak about their lives and experiences in their own words (Padgett, 2008). To this end, we used in-depth interviews and prolonged engagement to instill trust and enhance candor and to observe change over time. Although we recruited participants through low-threshold programs for homeless mentally ill people, the research relationship proceeded independently of program enrollment, thereby avoiding the "decontextualization of social worlds" (Lovell, 1997, p. 357) that characterizes studies conducted solely with services users.

Method

Sampling

The participant sample consisted of new enrollees at four programs for dually diagnosed homeless adults in New York City that offered treatment services and referrals including congregate and independent living. Staff at the programs invited every eligible client to participate in the study (individuals without *Diagnostic and Statistical Manual of Mental Disorders* [4th ed.; American Psychiatric Association, 1993] Axis I diagnoses of serious mental illness and without a history of substance abuse were excluded). Substance abuse was not required to meet *Diagnostic and Statistical Manual* criteria. All but 1 eligible client gave informed consent, and all participants were paid an incentive of $30 per interview and $10 each month for tracking and retention check-in calls. The study protocols were approved by New York University's institutional review board.

Data Collection Procedures

The design included three in-depth interviews at 0, 6, and 12 months begun within approximately 1 month of program entry. Interviews, which lasted from 1 to 3 hr, were conducted at the study's offices or the participant's residence. In total, 117 interviews with 41 participants were transcribed (3 missed their 6-month interview, and 3 missed their 12-month interview because of homelessness and/or relapse).

Interviews were conducted by four interviewers who were graduate students in social work, public administration, sociology, and public health (two women and two men). All but one had been previously trained and involved in qualitative interview studies with homeless mentally ill adults, and all received specialized training in this study's protocols. Interviews began with a conversational update, and then the interviewer inquired about current needs, service experiences, substance abuse, and mental health. Regarding social relationships, participants were asked about who was important to them, whom they could count on, who counted on them, family relationships, new or renewed social contacts, problems with friends or others, and romantic partners. The interviews were not designed to exhaustively elicit every possible social network constituent but to capture the relationships that mattered to study participants and the ways in which they mattered. All interviews were recorded and transcribed verbatim and entered into ATLAS/ti software (Muhr, 2004).

Data Analysis

Data for the case study analyses included the following for each individual: multiple interview transcripts, interviewer feedback forms for each interview (which included observations of the interview setting and the interviewee's nonverbal behavior), and psychosocial records procured from the referring program (obtained with the client's consent). A total of 2,245 pages of transcripts were reviewed, along with 351 pages of feedback forms, thus pointing to "evidentiary adequacy" in terms of time spent with participants and the wealth of data this produced (Morrow & Smith, 1995).

Using all available sources of data, a case summary was developed for each individual for the 12 months of study participation, with a focus on changes in residence and program enrollment, service use, substance use and abuse, mental functioning, and social relationships. Domains of social ties included family (parents, siblings, children, and others), romantic partners, friends and acquaintances, neighbors and peers (in the community and/or the congregate living facility), and others (someone such as a provider who did not fit the preceding categories).

We carried out multiple case study analysis in two stages: (a) across-case theme development and (b) within- and across-case analyses of individual trajectories (Patton, 2002). In Stage 1, Deborah K. Padgett began by reading (and rereading) case summaries and writing memos on observed patterns in how participants viewed their social relationships (as well as what these relationships were and how many there were). Team meetings were held to discuss emerging patterns, and discrepant cases were identified and discussed (e.g., a man who self-identified as a loner yet lived amid his extended family). We used such negative cases to refine or discard emergent themes to maximize their capture across the 41 individual cases. Data analysis for across-case themes ended when saturation was achieved, that is, no new themes emerged, and team consensus was reached.

Stage 2 of the analyses took advantage of the longitudinal data. Three team members independently reviewed case files and nominated individuals (Patton, 2002) as manifesting marked positive or negative progress in their recovery trajectories. Criteria for negative outcomes were one or more of the following: unstable living situation (multiple residential moves including episodes of home-

lessness), substance abuse (continuous or serious relapse), and poor mental state observed by the interviewers and manifested in one or more psychiatric hospitalizations. Positive cases had to show an absence of these problems and manifest increased hopefulness about the future (ascertained from interview transcripts and interviewer observation logs filled out after every interview). In what follows, we present findings as across-case themes and the patterns that emerged from the analyses of change over time. Thematic findings were reviewed with a three-member consumer advisory panel consisting of study participants who agreed with the findings as consonant with their experiences and the experiences of others in similar circumstances. Finally, we kept an audit trail to record analytic decisions and data used for specific analyses.

Results

Characteristics of the Participants

Most of the 41 study participants were male (71%, $n = 29$), and the mean age was 41, with a range of 21–60. The participant sample's racial–ethnic composition was 46% African American ($n = 19$), 29% Hispanic ($n = 12$), 17% White ($n = 7$), 5% Asian American ($n = 2$), and 2% mixed race ($n = 1$). Participants described their socioeconomic background as poor (27%, $n = 11$), working class (39%, $n = 16$), or middle class (22%, $n = 9$; 5 were unsure), and 27% ($n = 11$) reported education beyond a high school diploma or GED level.

Eighty-two percent ($n = 34$) reported spending more than 1 year living on the streets or in shelters. Axis I diagnoses (retrieved from the referring agency records) included schizophrenia (29%, $n = 12$), bipolar disorder (29%, $n = 12$), schizoaffective disorder (24%, $n = 10$), and major depression (12%, $n = 5$; 2 were unknown). A very high proportion (85%; $n = 35$) reported previous treatment for substance abuse, and 39% ($n = 16$) entered detox or substance abuse rehab during the 12 months of study enrollment; a higher proportion (73%, $n = 30$) attended 12-step groups during this time. Substance abuse (including crack cocaine, alcohol, powder cocaine, marijuana, and benzodiazepines) was reported by 57% ($n = 23$) of participants during the year. Thirty (73%) reported previous incarceration.

Sixteen (39%) reported never having children. Of the remaining 25, 10 (24%) had one child, 6 (15%) had two, 2 (5%) had three, 3 (7%) had four, and 4 (10%) had five or more. Broken down by gender, 17 of the men (59%) and 8 of the women (67%) had children. Of the 11 participants with children under age 18 (8 men and 3 women), none had primary responsibility for or lived with any of their children. Seven participants reported having a romantic partnership lasting 6 months or more (2 participants were in a long-term relationship with each other).

Themes From the Cross-Case Analyses

We identified four themes from the cross-case analyses: (a) solitude and connectedness, (b) family ties as good news and bad news, (c) when it comes to finding a partner, other things come first, and (d) in search of positive people. These themes, along with illustrative quotes, are described below.

Loner talk and privacy. Study participants often used "loner talk" when referring to themselves in relation to others. Such talk was usually framed as volitional but sometimes as "destiny":

> I'm the type of person that don't like taking nothing from nobody. . . . That's why I don't really associate with people because people could be really messed. . . . So I just stick to myself.
>
> I don't get attached to nobody. That's just me. . . . I don't want to get familiar with people because familiarity breeds contempt.
>
> It's like I just want to stay away from everybody. I'm antisocial. . . . I still don't like socializing with people. That's something that won't die.
>
> I've never been a social person or nothing like that. It's not like I don't want to be, but it's something I think I'm just destined to be.

A lack of trust arising from previous experiences was one reason given for isolation.

> I'm hard to trust in people. I've been in the streets since I was 11 years old so I grew up not trusting people.
>
> It's kind of hard for me to be really close with another person. . . . Both of my parents were alcoholics, and it's hard for me to trust people.
>
> It's a process of trusting again and that's what makes me a loner.
>
> I'm fine if I'm by myself. Nobody bothers me and I don't have nobody to bother.

Previous losses left some feeling bereft yet wary. Bernardo (all names are pseudonyms) said, "My friends . . . they've been killed or died of overdoses. . . . I'm the only one still around." Daniel traced his isolation to childhood rejection: "I don't have too much love for socializing with people. Ever since I was a child I never had too many friends. You know like, people like kind of avoided me most of my life."

Intensifying symptoms led some to withdraw from social interaction. When episodes of mania or depression flared up, Roger did not want family members to witness their effects and returned to the streets, sometimes getting on a bus and traveling to another city. "When I leave, I don't talk to no one about it, I just disappear."

For many participants, the absence of privacy was a problem in residential treatment settings. Gary said of the program that he left,

> I don't like sleeping close to no men. All my life I've been in shelters . . . but I always had at least this much space between the beds . . . [gestures width]. In [program], I couldn't get up and sit on the edge of the bed, 'cause my knees were right on his bed . . . that's just too close for me. And then the guy was snoring next to me every night and that was really driving me crazy.

Despite "loner talk" and a desire for privacy, none of the participants expressed a desire to avoid all social ties. As the following themes show, they wanted to pursue connectedness on their own terms.

Family ties: Good news and bad news. Family members could be sources of unconditional warmth and nurturing, but they could also be prone to rejection and condemnation, their cautious acceptance contingent on good behavior. What stands out in participants' accounts is the volatility of these relationships and the life stressors in which they were embedded and constantly being

negotiated. Parents, siblings, and other relatives were frequently beset by their own problems including mental illness, substance abuse, and severe poverty, all of which contributed to high rates of morbidity and mortality that thinned the ranks of family networks. Relationships could also be strained when a parent or sibling had the participant involuntarily committed or rejected the participant because of his or her substance abuse.

The bivalence of family ties is illustrated in the case of 24-year-old Mario and his mother, both of whom have bipolar disorder and live together in a tempestuous relationship. One day, after a fierce argument, she called the police and obtained an order of protection against Mario that he subsequently routinely violated (with her complicity) to visit her while she was hospitalized. Another example is Jaime, who is recovering from drug and alcohol addiction and who is close to his brother Roberto, who regularly buys him food and gives him cash; however, Roberto drinks heavily around Jaime.

Richie describes his own ups and downs,

> We're like buddy-buddy, me and my mom. About a year ago, we hated each other. . . . I was living with her, she drove me crazy. That's what made me go into the residence in B__. And, my dad died just recently. And that's what brought me back together with my family. . . . I figured, what the hell, why not just be close to them . . . why should I be distant with them?

With few exceptions, fathers were absent from participants' lives because of premature death or abandonment, and mothers were preoccupied with working and caregiving for others. Relationships with siblings ran the gamut from staunch support to total estrangement. David, on one hand, had three sisters who cared for him and stood by him during his worst years of substance abuse. "They just love me to death," he said proudly. Walter, on the other hand, had a prosperous brother who avoided him and a less affluent brother who remained in contact.

Although none of the participants with young children had custody or formal visitation rights, 4 men visited their children regularly with the mothers' consent. The 3 women with young children had almost no contact with them because of objections by the children's caretakers regarding the mothers' problems. In contrast to their other family ties, participants' relationships with their children (whether active or hoped for in the future) were consistently a source of positive motivation. Juan, who has four children living with two mothers said, "My kids . . . we have a real good understanding and we communicate a lot . . . and the mothers know each other because that's one of my rules. I don't want to hear it, so they get along and understand." Maria reflected on her 20 years of substance abuse, homelessness, and estrangement from her four adult children (who were raised by a sibling): "I'm trying to earn the trust, but I'm not going to earn it overnight, you know? . . . I just want to hug [my son], you know? But little by little, I'll get there."

Finding a partner: Other things come first. Seven participants reported having a romantic partner of 6 months' duration or longer. At his 6-month interview, Juan spoke of Irene, a woman who befriended him while homeless: "She makes sure I take my medication every night . . . she talks to me about positive things. She says 'you gotta keep motivated.' So she helps me with that and she buys me clothes."

Four participants expressed a strong need for a romantic partner. Bernardo was emphatic: "I've prayed for it. Someone that I could help and she could help me. 'Cause I don't want to die alone. I'm going on 59 this year . . . I don't know how long I'm gonna live." Anita said she stayed with a boyfriend who paid little attention to her except when he needed money. "I gotta . . . have some sort of life. That's the only reason I put up with him. I haven't got much to choose from!"

Most, however, did not consider a serious relationship to be an immediate need as they had more urgent priorities. With regard to his ongoing substance abuse, George said, "I'm gonna have to get myself together first before I find someone else." Louella noted, "I don't let nobody in until I get where I am going. Then I'll start looking around."

Concerns were voiced about emotional and other demands of an intimate relationship. Daniel said, "That's why I try to have no girlfriends. They make my life difficult."

Participants also wanted to be in a better position to offer something to a prospective partner. As Louella explained, "How do you have a boyfriend or girlfriend when you're homeless? Sooner or later they're going to kick you out. Ain't got no benefits, no welfare, no kind of check . . . you're useless."

Deferring the search for a partner was linked to past experiences as well as current concerns. Calvin said, "When a female starts gettin' close to me, I get scared. 'Cause I've been through so much domestic shit with girls—fightin' and carryin' on—that I don't never want to go through a domestic thing with a female again." Gary stated that his HIV status made him wary of relationships.

> I got three boys by two different women. Both mothers of my children I would like to be back in touch with . . . doesn't have to be no sex, no relationship, nothing like that. Which I wouldn't do in my predicament anyway, and they don't know I'm HIV positive. But the thing is, I wouldn't now. I'm strictly abstinent these days.

Whether constrained by poor health, struggles with substance abuse, a lack of resources, or fears of unhealthy entanglements, participants had other social priorities such as making trusted (especially sober) friends and reuniting with family. This stance did not preclude a romance in their future, but it did attest to participants' desire for autonomy in charting their own course toward becoming involved with others.

In search of positive people. The social circles in which participants traveled were heavily populated by individuals with substance abuse, poverty, and other problems. As 1 young woman said, "I don't have friends 'cause all my friends use drugs." Participants lamented a lack of social ties because of a scarcity of money and resources. Daniel explained, "It's like you've got to have things . . . to offer to have friends and stuff like that. If you don't have nothing, you're not really gonna have friends . . . you've got to have, uh, cool stuff." Randolph felt his sobriety enabled him to reach out more effectively to others, but he was frustrated by being unemployed. "I don't have a job where I can be out there with people that I could have a mutual respect. Being around . . . positive people."

The 12-step admonition to avoid the people, places, and things that might trigger a relapse has particular resonance for study participants, but it also put them in a bind. Those living in congregate treatment settings had strict curfews and supervision to prevent such temptations, but more than half left these settings and

"went AWOL" during the study. Those living in their own apartments did not have such restrictions but were thrust into new neighborhoods that were poor and sometimes drug and crime ridden. Attendance at 12-step groups provided support in recovery, but some of the group members still used drugs and alcohol on the side and thus exerted a negative influence. One participant, for example, took his brother-in-law to a Narcotics Anonymous meeting and was shocked to see him "pick up" immediately afterward on encountering drug dealers waiting nearby.

Peers who were still abusing substances or not moving toward recovery in other ways often fell by the wayside. Jane said, "It's just that there comes a point in one's life that you have to move on. . . . I don't want to surround myself with a person [sic] who doesn't want anything . . . that kind of rubs off on me." George explained further, "When you use, you got many friends. . . . Everybody opens the door. But once I decided to go clean, it's like, I don't fit in the crowd no more."

Providers and programs were sometimes mentioned by participants when asked whom they could rely on. This was not surprising given their dependence on and daily proximity to staff working in residential programs. However, client–provider relationships were temporary, by virtue of the program's transitional approach, high rates of staff turnover, or participants' premature departure. Clients witnessed staff turnover with dismay and at times a sense of personal loss. As Diane noted on the departure of her favorite case manager,

> After we found out that MaryAnn was leaving, me and one of the girls sort of went ballistic. I started punching stuff. She started punching stuff. Everyone was crying. So MaryAnn grabbed both of us into her office and told us that she had never felt so much love between us, and it looks like me and her, the girl that was also breaking, need more attention until she leaves.

Patterns of Change Over Time

On the basis of the selection criteria outlined earlier, 10 cases achieved 100% independent agreement by the three raters, 6 for the negative trajectory group (all men) and 4 for the positive trajectory group (2 women and 2 men). For these 10 people, we analyzed the case files to examine their social relationships and how (if at all) they had changed over time.

Among members of the positive trajectory group, 2 had romantic partnerships (1 reunited with his kids' mom during the study, and the other was in a long-term relationship with a man she had met while homeless). The other 2 persons in the group were (by their own accounts) socially isolated. The latter included a gay man (Geoffrey) who had strained relations with his parents and siblings because of his sexual orientation (although he was close to one aunt). The other participant, a woman in her 30s, was recovering from addiction and hoping to regain custody of her three young sons. She had a boyfriend at her residential program for a few months, but the relationship did not last. She reported few contacts with friends or family.

With regard to the negative trajectory group, 1 member (Juan) had a serious girlfriend and regular contacts with his mother, siblings, and three children (as well as their mothers). Calvin maintained close and regular contact with his four children but had tenuous relationships with their mothers (one of whom was living in a homeless shelter) and was estranged from his family. The remaining 4 members of this group were much less affiliated. One man was tried and put in prison for assaulting his girlfriend, and another spent most of the study year living alone in a structured treatment residence because of serious long-standing drug abuse. The final 2 members were mentally unstable (1 also had effects from a traumatic brain injury) and had few contacts with family or friends as they moved from hospitals to jails to shelters.

Three noteworthy observations emerged from the longitudinal analyses. First, social connectedness was not associated with progress in recovery in anticipated ways. Thus, Juan led a turbulent life on the streets yet had many supportive friends and family. By the same token, Geoffrey was maintaining his recovery from addiction and felt optimistic about the future, yet lived in relative isolation. Second, the pacing of trajectories revealed that progress in recovery was gradual and cumulative, losing ground could be sudden and disastrous, and staying the course often meant being stuck on a plateau with few options for positive change. Third, classifying individual trajectories—even provisionally—is a challenging proposition given the volatility and multidimensionality of their lives.

Jennifer's story exemplifies the fragility of hard-won gains. Jennifer entered the study having recently moved into her own apartment. Over time, she reported having several supportive friends and improving relationships with her family. She also found a part-time job in data entry and noted that she had formed friendships with several neighbors in her building. Yet these neighbors, with whom she shared meals and an occasional marijuana joint, subsequently offered her crack cocaine, and Jennifer's life spiraled into addiction, unemployment, and panhandling.

For Gavin, the lack of stable independent housing overwhelmed other efforts to gain traction in recovery. Having achieved stability from medications for bipolar disorder and faithful attendance at his methadone clinic, Gavin met a romantic partner with an infant girl shortly after entering the study and reported that he was finding new meaning in life with this ready-made family. Yet the three were evicted from Gavin's single-room occupancy and forced to move to a new family shelter every 10 days.

> Tonight when I go back there could be a letter under the door and we were found ineligible. Then we have to pack up and go down there . . . and get housed for overnight, and then have to go back and sit there all day tomorrow until they house us for 10 days. And then like that and start all over again.

Gavin admitted to a risk of relapse but was trying to hold his own: "A couple of times I got stressed out. . . . I just wanted to hit the streets and become homeless and just forget about everything."

Discussion

Four themes emerged from the study's findings: (a) a professed need for "loner talk" and privacy and a desire for meaningful relationships and companionship; (b) volatile and often strained ties with family members whose support was eroded by having their own troubles; (c) a preference for deferring intimate partnerships until a more stable life was attained; and (d) difficulties in achieving positive lasting social relationships because of ongoing struggles with substance abuse recovery as well as the social environment and service settings in which participants moved. For those with children, contacts varied in frequency but remained a

source of positive motivation even when hoped for rather than real. Trajectories of change could be gradually moving forward or plummeting downward, and many participants were stuck on an uneasy plateau.

Participants lived amid “concentrated disadvantage“ (Sampson, Morenoff, & Raudenbush, 2005, p. 226), that is, a confluence of poverty, crime, and substance abuse found in many inner-city neighborhoods. Similar to the findings from a previous study (Hawkins & Abrams, 2007), we note that participants had relatively few trustworthy friends and family to call on or confide in. When available, social relationships could propel them forward or pull them back—or both. Regardless, such relationships rarely brought social capital or access to valued resources and information.

Amid such social and economic deprivation, participants' recovery was threatened by factors that extended beyond limited resources and social support. Substance abuse, the most dramatically evident of these, was so pervasive on the streets and in shelters that one might better ask why so many homeless persons do not use under these circumstances. In addition, drug and alcohol use constituted one of few forms of social currency; thus, cessation meant losing what few “friends” they had.

Central to a recovery philosophy is the concept of choice, whether in treatment decisions (Deegan & Drake, 2006) or other arenas (Farkas, Gagne, Anthony, & Chamberlin, 2005). Just as close and supportive ties may be sought as valuable, social distancing may be initiated as a means of enhancing recovery and emotional stability (Corin & Lauzon, 1992; Sells, Stayner, & Davidson, 2004). This study's findings highlight the constraints on participants' exercise of such choice, whether it was programmatic restrictions or larger social forces depleting social network availability.

Limitations

We acknowledge that the data provide a “year in the life” when recovery is typically a much more gradual process. Our urban participant sample, although drawn from low-threshold programs, did not include homeless persons who refuse all services nor does it represent the experiences of homeless persons in rural areas. Because of the sensitivity of the topic and a focus on current life conditions, we did not directly inquire about histories of physical or sexual abuse even though such traumas are common in this population and could play a role in seeking or avoiding social connections (Padgett, Hawkins, Abrams, & Davis, 2006).

Strengths of the study include prolonged engagement, member checking, multiple sources of data (including interviews, observation, and agency psychosocial records), immersion in 41 cases and 117 interviews (pointing to evidentiary adequacy), and maintenance of an audit trail documenting analytic decisions. Team members met regularly to debrief after interviews and discuss analysis plans; findings and negative cases were introduced to guard against premature or misleading conclusions (Padgett, 2008).

Implications

This study presents several implications for providers and programs assisting in the recovery and social integration of persons with psychiatric disabilities. Having stable housing is pivotal, yet the potential for social isolation should be anticipated by providers and ameliorated as much as possible. The absence of choice in supervised on-site residential programs can lead to abrupt disengagement (more than half of these participants went AWOL during the study). Supervised congregate living also increases clients' dependence on providers and other program residents. Such relationships, almost always transitory, rarely provide (or can be expected to provide) the closeness and unconditional warmth of friends and family.

Programs can be responsive to clients' need for autonomy as social beings. One-size-fits-all assumptions obscure the complexity and change inherent in relationships with family and friends. In this study, the benefits of having a romantic partner were not dismissed (and were enthusiastically embraced by some), but for most participants they were deferred in favor of trusting, less demanding relationships. Promising developments in assisting this type of social integration include initiatives such as supported employment (Becker, Whitley, Bailey, & Drake, 2007), recovery housing (Whitley, Harris, & Drake, 2008), and capabilities enhancement (Ware, Hopper, Tugenburg, Dickey, & Fisher, 2008).

Meaningful social relationships—in whatever quantity or quality desired by the individual—remain one of the recovery era's greatest challenges. Resource-strapped providers cannot be held responsible for their clients' social integration, but they should not hinder it either. People with histories of mental illness and homelessness are said to lack social currency, but several of the participants in this study were able to forge supportive relationships despite having few resources and being almost constantly exposed to drugs, crime, and other threats to their well-being. This resilience could be enhanced considerably by having a stable residence and adequate resources to engage in reciprocal relationships.

Interestingly, progress in mental health recovery appeared dependent more on gaining control over substance abuse, avoiding negative social ties, and attaining independent housing than on achieving psychiatric symptom reduction per se. Clearly, progress toward recovery for dually diagnosed homeless persons is a complicated undertaking—it is difficult to imagine a more disempowered and disadvantaged group of individuals. Although public education and advocacy can reduce the impact of societal stigma, the deleterious effects of cumulative adversity are not easily remedied under current social policies. Nevertheless, programs and providers can play a key role in assisting individuals make the transition toward a recovering life.

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Received May 20, 2008
Revision received May 20, 2008
Accepted June 6, 2008 ■