

Constituting Community: Creating a Place for Oneself

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This article, a qualitative research project based on grounded theory, illustrates processes used by a group of individuals diagnosed with schizophrenia to create a self-authored community. These individuals were long-term residents (continuous residence for more than 1 year) of a large psychiatric hospital.

The results illustrate the challenges people face in forming relationships. The process of venturing forth and connecting begins cautiously, with few expectations. It is closely related to facilitative environments, such as public places and place of residence, and to routines, daily activities, and facilitative objects, such as coffee and cigarettes. These environments have few interactive demands and feature the presence of other people. The process is also related to past experience and current relationships, both real and virtual.

We found some disparity from what is reported in the literature concerning the connection between relationships and staying out of hospital. The participants clearly visualized relationships as connecting them to the wider community and providing hope, and not necessarily linked to staying out of hospital. This disparity may be linked to these individuals having short community tenure. It may also be related to the small sample size.

We argue that venturing forth and connecting is a useful concept when considering how individuals with long hospitalizations connect to a community. We consider that the actions of people recently discharged from long-term care should be seen as relatively normal and part of the struggle we all face in living in the world together.

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This research was supported by a research grant from the Centre for Addiction and Mental Health, Grant Research Committee in Toronto.

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Mental health reform in the province of Ontario, as in many jurisdictions, emphasizes community living arrangements and supports alternatives to inpatient care (Ontario Ministry of Health, 1999). However, the goal of community living, often equated with community integration, remains elusive. Living in the community has been associated with loneliness, despair, and difficulty forming meaningful social relationships (Borge, Martinsen, Ruud, Oyvind, & Friis, 1999; Davidson et al., 2000), despite abundant literature indicating that individuals with severe and persistent mental health problems prefer to live and be treated outside of hospital settings (Davidson et al., 2000; Honkonen, Saarinen, & Salokangas, 1999; Okin & Pearsall, 1993; Ontario Ministry of Health, 1999).

Having a psychiatric diagnosis and maintaining one's community life has long been a concern of mental health practitioners. It is recognized that extensive hospitalizations have tended to disrupt community living. There is a wide literature on various alternatives to hospitalization including community-based treatments such as Fairweather Lodges (Mosher, 2001). Fairweather Lodges are an interesting example of how individuals with serious mental illness participated fully in a community (Fairweather, Sanders, Maynard, Gessler, & Bleck, 1969). The success of this project was largely due to both parties, the treatment team and the client, being confident of being able to manage in community settings. In this model, the client/practitioner relationship was developed within a context of mutual trust and positive expectations. Examples such as this give credence to the importance of relationships, and we argue that it is the relationships that the clients develop themselves, no matter how apparently tenuous, are as important to community tenure as those with professionals.

The literature suggests that individuals with severe and persistent mental illness due to psychosis have great difficulty developing relationships and that the relationships they do develop are unidirectional, non-reciprocal, and limited in scope (Anthony, Cohen, Frakas, & Cohen, 1988; Davidson, Stayner,

& Haglund, 1998; Hamilton, Cutler, Weigel, & Ponzona, 1989). However, recent findings indicate that people do develop networks that enable them to remain in the community and to have an improved subjective quality of life (Bengtsson-Tops & Hansson, 2001; Clinton, Lunney, Edwards, Weir, & Barr, 1998; Laliberte-Rudman, Yu, Scott, & Pajouhandeh, 2000; Pomeroy, Cook, & Benjafield, 1992).

Meaningful personal, voluntary relationships (often termed friendships) developed by the individuals themselves are of the utmost importance in building a life in the community. As noted by Boydell, Gladstone, and Crawford (2002), we need to increase our understanding of relationships and friendships formed by people with severe and persistent mental illness in the community. The process in which such individuals engage as they go about trying to create a self-authored voluntary community have not been fully explored. We believe that the steps individuals take voluntarily to open interaction opportunities and establish a link with others in the community, though sometimes viewed as superficial and meaningless, are a necessary part of developing a sense of belonging. The present study was intended to narrow the gap in our understanding of this relationship-building process, especially regarding the factors that enhance or inhibit it.

Two recent studies (Cohen, Talavera, & Hartung, 1997; Davidson et al., 1998), one on friendship and one on community integration, identified four types of factors and five personal predictors regarding the formation of friendships and the fostering of community integration. The four types of factors are environmental (physical proximity and contact through adult roles), individual (physical attractiveness, interpersonal responsiveness, social skills), situational (availability for friendships and frequency of interaction), and dyadic (reciprocity and self-disclosure). The five predictors of community integration are male gender, absence of loneliness, being older, having reliable social contacts, and having few perceived life difficulties. The findings of Cohen and colleagues support the idea that

subjective well-being is dependent on how people view their own lives and circumstances. If people say they have reliable social contacts and are not lonely, this helps to create the conditions for community tenure, even if others might not view their relationships as reliable. They then feel good about themselves and are satisfied with their life in the community. What is important is that the people themselves report that they are satisfied with the quality of their relationships and are not lonely.

We argue that it is the individuals themselves who create and maintain a community, under a variety of conditions. People are the authors of their relationships, deciding where and when to have them and the process involved in their creation. Cohen's (1985) phrase "practising being social" captures this process. As they go about their routines—taking little walks, stopping for coffee—people slowly develop relationships within the community. These self-developed ties provide a sense of belonging and well-being (Lin, Ye, & Ensel, 1999). The process is not very different from what anyone might do when they find themselves in a new environment. Anecdotal evidence reveals that after moving to a new city, people create little routines—go to the grocery, begin talking to neighbors—and go about their daily business, which includes being with others in one way or another.

According to Boydell and colleagues (2002), the ability to create a community, which resides in engagement in regular interpersonal interactions, is lacking in individuals with severe psychiatric disorders. However, Beal (1999) found that individuals with schizophrenia, some of whom were severely impaired, were able to engage in such interactions as they went about their daily lives, chatting with others on a regular basis, creating loose contacts. Consistent with the enabling conditions noted above, a particular environment helped them to develop those contacts. People found a place where meeting and talking with others was a natural daily occurrence. They took the same bus every day and talked to the driver, spoke regularly with the clerk at the grocery, or sat in a shopping mall

at a time when others would be nearby, thus creating a feeling of belonging and allowing relationships to form. People used the community as a resource, finding places with relatively low-key interactive and time-limited demands. The participants in Beal's study spoke enthusiastically about what they had learned by taking part in "virtual interactions"—interactions in which the person is alone but interacts with others vicariously through radio or television. Although activities that take place in isolation may be viewed as indicative of dysfunction (Avison & Speechley, 1987), such activities made these participants feel connected to a community, allowing them to share in events without having to worry about actually talking to somebody.

The present study was designed to uncover the various conditions under which community is self-authored/created by a group of long-term residents (continuous residence for more than 1 year) of a large psychiatric hospital when discharged into the community. It examined the idea that in community settings that offer opportunities to practice being social, individuals with severe and persistent mental illness are able to build and maintain a self-authored community, forming relationships that they themselves consider friendships.

As noted by Boydell and colleagues (2002), research on friendships among people with psychiatric difficulties has concentrated on the issue of support. The present study, in contrast, addressed how people themselves develop such alliances by exploring the processes and factors that facilitate or hinder opportunities for such relationships to form.

PURPOSE

The overall purpose of the study was to examine the contexts and relationship-building processes involved in creating a self-authored community by individuals with severe and persistent mental illness who have been hospitalized consecutively for at least 12 months immediately prior to discharge.

The objectives of the study were to: (1) define mutual relationship from the point of view of the participants; (2) determine the environmental conditions that foster the ability to practice being social; (3) examine how the participants use opportunities to be with others without interacting overtly, resulting in a sense of belonging; and (4) examine how participants interact virtually in order to feel connected and part of a community.

METHOD

Seven individuals (four women and three men) living in a large Canadian city with an Axis I diagnosis of schizophrenia (American Psychiatric Association, 1994) were interviewed. Each participant had been an inpatient for a minimum of 12 months immediately prior to discharge. Six of the participants lived in boarding houses and one lived in a subsidized apartment building. Four were single, one was married, one was divorced, and one was widowed. Although specific ages were not obtained, the participants indicated their age category. Three identified themselves as 40–49, one as 20–29, one as 30–39, and one as 50–60. One participant said she was under 20 but appeared to be between 40 and 60. In terms of ethno-racial background, five participants described themselves as English-speaking Canadians, one as Italian Canadian, and one as Black African Canadian.

The study was a qualitative investigation using a grounded theory approach. Following approval of the hospital ethics committee, the researchers held a meeting with case managers who worked with potential participants to inform them of the project. The case managers then approached their clients to ask if they would be willing to learn about a research project. The subjects understood that agreeing to learn about the study did not obligate them to participate. As each individual expressed an interest in learning more, one of the researchers approached him or her to describe the study. The research assistant then contacted the person to set up an interview, thus giving the potential partici-

pant time to reconsider. The participants were interviewed at a place and time of their choosing so that they would control the schedule, setting, and circumstances of the interview. After obtaining informed consent, the research assistant, who had a background in mental health, endeavored to interview each individual twice, at 3 and 6 months post-discharge, using a semi-structured questionnaire as a guide.

Three of the participants refused the second interview. One was institutionalized at the time of the second interview and, although he agreed to meet with the research assistant, refused to participate. Another agreed to meet with the research assistant three different times but ultimately declined; the first time he failed to show up, the second time he asked the research assistant to return at more convenient time, and the last time he simply refused to participate, indicating that he was not interested. The third refused to participate before the research assistant had an opportunity to meet with her the second time, commenting that she remembered the first interview but did not want to do another.

At the beginning of the interviews, the research assistant informed the participants of their right to withdraw from the study at any time without repercussions. Each interview lasted approximately 45 to 60 minutes and was audiotaped and transcribed with the participant's permission. The research assistant conducted all interviews and kept field notes. During the study period she met bi-weekly with the research team and more frequently with the principal investigator. All data collection instruments, tapes and transcriptions, and interviewer notes were kept in a locked drawer in the principal investigator's office. The use of code numbers throughout the study ensured confidentiality. A master list linking code numbers to specific individuals was kept by the principal investigator until the study was completed, then destroyed.

Data analysis was carried out using grounded theory, a method frequently used in health research, particularly with chronic illness, providing a variety of strategies and ap-

proaches to inquiry. The method focuses on the data as a way of developing analytic and conceptual constructions about an issue (for example, that individuals suffering from serious and persistent mental illness seem to have difficulty with community tenure). Basic ideas and theories arise from the data, which focus on the lived experience of the participants (Charmaz, 1990, 1999). As the data are collected, researchers are able to obtain a window into the world of the participants, which in turn informs further data collection. The process is shaped through analysis of the observations and the themes and categories as they emerge.

Concepts noted in the literature can serve to guide the process. For example, we knew that people with severe and persistent mental illness are able to find ways of forming relationships that they term as friendships. We were particularly interested in the social conditions that enabled them to discover ways of forming friendships. Fine's (1992) concepts about rules and resources that are available to people in interactive situations were particularly helpful. Rules and resources are understood in terms of what actions are possible within certain contexts and the systemic limitations to such actions.

Themes discovered in the interview process are followed up as the research progresses. Researchers look for conditions that may contribute to phenomena—for example, conditions that enable people to meet and interact with others. The data are said to be saturated when they reveal repeated evidence and explanations for a category (Charmaz, 1990). This method allows the individual's perspective to shine through. The data are continuously examined in order for the researchers to develop theories about what is happening, to link these data together, and to interview the participants further to see whether the theories hold up. The research team met frequently to discuss the interview content in order to identify emerging themes and concepts as well as to discuss any new directions to be taken during the interviews. From these data, key theoretical categories surfaced and the relationships among the categories were analyzed. Concepts discussed in

the literature served to guide this process initially. Interviews continued until the data were saturated.

We knew that people with severe and persistent mental illness, despite many interactive difficulties, are able to find ways of making friends. We were interested in the social conditions that enable them to do so. Further, we understood from Fine's (1992) work that the rules and resources available in various environments can be used as interactive opportunities—for example, in coffee shops during off-hours. This premise set the questions we would use to tap into the lived experience of creating a community, knowing that as we progressed with the data further themes and theories would emerge.

FINDINGS

Two themes emerged from the data. The first of these we have termed *venturing forth and connecting*: the participants had discovered ways of venturing forth and connecting with others. These were linked to what we have termed *facilitators* to interaction: environments, objects, relationships (real and virtual), routines, and past experiences. The process of venturing forth and connecting involved discovering, within the participants' own environment, conditions that allowed relationships to develop. What is striking, in this case, is how the venturing forth and connecting process was linked to place, facilitators, and relationships. This finding is elaborated below.

Venturing forth and connecting refers to a process of moving beyond not only one's own space but also the space bounded by treatment teams, for the purpose of connecting with others. Angell (2003) discusses the dilemma in which treatment teams often find themselves: They try to create social opportunities only to find that they have built a subculture of client-only social groups. The participants in the present study spoke of the challenges they faced in the process of venturing forth and connecting with others. However, there seemed to be a will to get out on one's own and find opportunities for interac-

tion unconnected to treatment teams. This process was enabled by *facilitators*.

Facilitators refer to situations and things that make interaction easier to initiate and maintain. The data revealed four facilitators to interaction: (1) the environment in which people lived and which featured simple places for them to go; (2) routines, daily activities, and objects, such as cigarettes and food, which also provided context; (3) past experiences, which give a comparative context to relationships and are linked to hope for the future; and (4) people with whom to go places.

Venturing Forth and Connecting

The participants used simple strategies for venturing forth and connecting. There was no discussion of so-called normal relationships or relationships outside the mental health network. This finding sits in contrast to Angell's (2003) finding of a strong expressed desire for relationships outside the mental health network. The simplicity of the strategies—going for walks, sitting in parks—and the absence of concern about stereotyping or the stigma of mental illness are likely a result of the relatively short tenure in the community and limited expectation of friendships.

ENVIRONMENT AS FACILITATOR

As people ventured forth, the environment was a ready-made source of relationships. Some of these relationships were virtual—involving interactions with the television or even, in one case, fictitious individuals. Others were with family members, non-clinical staff at their place of residence, or people they met as part of their daily routine. Participants spoke of engaging in activities that placed them with others, which created opportunities for connectedness. Consistent with Beal's (1999) findings, these activities tended to be low-key and time-limited.

Public Places

What was important was the environment itself, with its opportunities for interaction: the park, the mall, the streetscape. Such places allowed the participants to connect:

I'll sit on a bench and watch children play in the water pond in the children's playground.

The mall, with its stores and coffee shops, offered a sense of connectedness:

You know, the areas where you just sit around . . . after walking around so long you get tired. You just want to sit down. You look at other people do their thing.

I'm alone in my apartment and it gets stifling after awhile . . . sometimes I see people I know, from the building. A lot of people from my building come here, and we all hang out here together . . . Sometimes I sit in [name of restaurant] or in front of a store . . . I'll sit on the bench and watch people . . . sometimes they do sit down beside me and start talking. I find it very easy to talk to people who start talking to me. I can easily carry on a conversation with that kind of person, like, a very outgoing person. So I get along well, and it makes my day brighter and I go home stepping lightly. So I feel better, you know. It's interesting, you find out little things that you can tell a friend, and they'll feel better by hearing it. That's what I mean. It makes your day brighter and a lot more easy in the heart.

Place of Residence

One environment that presented the context for relationships, either facilitating or hindering them, was place of residence:

I know people in the building. They are all very friendly people. I get along fine. I don't know them that well, but I get along well with them . . . there are a few people in the building who I visit more often than others . . . every couple of days, sometimes every day. But

there's a break sometimes I don't go there, about three days, and I'll go back there.

I talked to them every day . . . I don't share my personal stuff . . . we cooked together . . . They were never angry. There wasn't . . . anything wrong with them. There wasn't anything I didn't like about them.

Place of residence took on more importance as time went on. For example, during the second interview one participant stated, "[My roommate] is my friend, I guess." This illustrates the fragile, tentative nature of developing relationships.

If the place of residence was less than welcoming, the participant found it greatly disappointing:

When I first came in there, I felt like I'd be able to make girlfriends and boyfriends, but it's been a long time and now I can't. I haven't been able to make any girlfriends or boyfriends.

Another participant spoke of the place of residence in negative terms: "It was noisy. I had to share a room with somebody."

Routines, Daily Activities, and Facilitating Objects

Just as place of residence facilitates connectedness, routines and walks also offered opportunities for interaction:

I wake up and have a shower, eat breakfast, make my room, go outside, then its lunchtime, then I talk to some friends. I don't like to sit in my room. I hate [the] bedroom. I can't sit there.

[On a normal day] I go for walks, down to the . . . pond, down the street, west of my address. I see children there in the summertime. I'll sit on the bench and watch the children play in the water pond, on the playground, and ground rides . . . I like to watch the children with all the mothers looking after them.

One participant knew she was becoming ill again because she had lost her routine:

I've lost all my routine. Now I am living very, very poorly. All my standards are gone. I have no pride or rules for myself.

Another disliked the environment in which he had been living because it had no meaningful routes for him to walk or places where he could develop a sense of belonging in the community:

I left the hospital knowing that I was going to get out of my single apartment that was so lonely—there's never any traffic, never anyone walking up and down the street, very [few] grocery stores. . . . I was left feeling I needed more, more places to walk, to shop, to look at thrift stores.

The interviews revealed many examples of participants using facilitating objects in order to increase their sense of belonging to a community or to initiate a conversation—for example, having coffee, eating in a group situation, or using a designated place to smoke. One participant said, "I just talk to whoever is in the smoking room."

The opportunity to have coffee, a soft drink, or a meal gave meaning to "sitting around" with others. It offered a sense of purpose and of belonging and motivated the person to venture out. In addition, it added an element of reciprocity to the relationship:

We cook a meal and then we sit down and eat it . . . we have to pay a dollar each time.

The following comment about a mother makes it clear what could be asked of another person:

She probably wants to [help more] but I can't ask her [to do] everything. I want to go and get something, I go get it myself. I never ask too much.

PAST EXPERIENCES

In exploring the challenges of venturing forth, five of the seven participants spoke of past experiences as both enabling and challenging. Some of the memories were good and some not so good. One woman reminisced about happier times with friends:

I used to have my 18 girlfriends, and I used to walk to school with them every day, and sometimes we would drive to school . . . We used to go to McDonald's and Harvey's and Wendy's, and we used to do homework. Valerie and me, one of them, she'd come to my bed on [name of street] and we'd do our homework together. But I lost all my girlfriends because of my health problems.

Some spoke of not having friends:

I don't really talk to anyone. I don't have many friends. I don't have too many friends. I dropped all my friends because they were using drugs, and I said I didn't want to be a part of that. And I worked too hard on my studies so I didn't get many friends . . . I was too busy studying mathematics.

There is little doubt that people with severe mental illness experience difficulty forming meaningful relationships (Borge et al., 1999; Davidson et al., 2000; Davidson & Stayner, 1997; Doubt, 1992, 1994; Estroff, 1983). Further, loneliness can be a life-long problem (DeNiro, 1995; Honkonen et al., 1999). The participants in the present study used the past to connect with the present and as a way of finding a path out of loneliness.

Some authors argue that the relations of people with severe and persistent mental illness are unidirectional and are narrower and less reciprocal than those of other people (Anthony et al., 1988; Davidson et al., 1998; Hamilton et al., 1989). In the present study, relations seemed to be limited, but when reciprocity was part of the interaction, the individuals acted accordingly. The limited relationships are likely due to very early attempts

to establish oneself in a place and form relationships. Consistent with the findings of Beal (1999), the participants made a clear distinction between friends and family members. One participant described a friend as someone with whom one does things:

[With a friend you do] things together in the city of Toronto . . . I think there was a CHIN picnic today, and I couldn't go because of the surgery . . . Stuff like that, you go with somebody.

CURRENT RELATIONSHIPS—REAL AND VIRTUAL

Family

Family members, on the other hand, could always be counted on. They were viewed as advocates and as a means of connecting with others:

I always have a mother to go home and see . . . I'm lucky I got some family sticking with me.

[My brother] is a nice guy. I don't think that he's ever going to hurt me. He keeps badgering me to do something with my time. I go up there . . . I don't think that he would hurt me.

One participant spoke of the difference between a relationship with a family member and a friendship:

She [family member] asks me if I want something. She gets them and brings them to me. Friends never do that.

Another participant identified all of his meaningful relationships as involving family members. He spoke of his mother most often and most fondly, then his brothers and his deceased father. He elaborated on the difference between family and others, including health-care providers:

They've known you longer, they know of

your habits, they know when you're well, they know about your money, they know things about you that the doctor doesn't know.

One participant described her relationship with her father:

My father helps me a lot, he always has . . . He's incredibly strong, and I really look up to him. I try to even act like him sometimes. I try to act as strong as he is and he helps me so much, because he is very calm and logical, very quiet, tells me exactly what to do to get out of what situation I am in, because I ask him that.

Health Care Providers

Consistent with the findings of Beal (1999) and Boydell and colleagues (2002), the participants reported that their relationships with health-care providers met some of their relationship needs. One participant spoke fondly of his interactions with the nurse:

I really just talk to the nurse that comes to see me every week . . . [We talk about] just anything . . . mainly jokes . . . we just tell each other jokes, humorous things.

Two participants also seemed to enjoy interacting with the interviewer. At the end of an interview, one participant asked, "Is that it?" When the interviewer replied, "Yup, I just want to remind you that I'll be seeing you again in 3 months," the participant said, "Oh, after that long." Several participants commented, by the second interview, on the research assistant being a friend: "You're my friend while this survey is going on." This remark clearly shows that the participant understood the full context of the interview and that friendship can be voluntary and time-limited.

Virtual Relationships

Virtual relationships have not been much discussed in the literature. As noted in

the quote below, the subjects knew the difference between imaginary relationships and delusional ones. Further, when asked why they liked TV, one replied, "It talks nice." In this study we interpreted such relationships as connecting someone to a community even though the actual people were not present. For example, the television was described as affording a sense of connection: "watching soap operas and enjoying feeling the anticipation." Some participants spoke of imaginary family or adventures. One participant who had no friends or loved ones spoke of a fictitious grandfather/father relationship:

It's sort of like a delusional thing, he's sort of like a father but it's . . . supernatural. I know that in time, time will heal, and I know that when he leaves I'm going to have to basically understand the ways or I'm going to have to go back into schizophrenia.

It is clear that he understood the fictitious nature of the relationship, but it connected him to an understanding about relationships that guided his thinking. Further, it offered comfort, as did the imaginary travels of another participant:

I've never really travelled too far by plane, but with my imagination I can be anywhere . . . I'll go off to places like Egypt or Turkey or . . . Asia, and just keep travelling and looking around . . . I like the architecture and the people's dress. It's not real, it's just imagination, but it's my own little movie that I build up on. Then I visit the [United] States, and I go through the states and I know all the states from the history books.

A number of researchers have suggested that a network of relationships helps people with severe mental illness remain in the community. The participants in the present study, however, saw relationships as being of limited benefit in keeping them out of hospital or staying well. When asked whether a daughter and friends, respectively, helped them stay out of hospital, two participants replied, "No, she can't do that" and "It didn't really make any

difference.” Another spoke of people trying to help him but with little success:

Sometimes they try to help if I'm feeling depressed . . . No [it does not help] that is all controlled by the drugs. I am controlled inside. Yeah, they try. But sometimes I don't like to talk to them . . . No [it doesn't help keep me out of hospital]. The drugs help for that.

These remarks are likely related to how the person experienced the illness and the effectiveness of treatment. The assistance of family and friends, while appreciated, does not help to keep clients out of hospital. Perhaps the time has come to reframe the important role played by family and friends while acknowledging that they cannot make a contribution concerning the illness itself. This role is, perhaps, restricted to the treatment team.

HOPE FOR THE FUTURE

Connections with hope refers to the degree to which participants made a connection between developing a network of relationships and hope for the future. One woman said:

I push myself . . . I'm trying to get a figure . . . I'm worried about my figure, for men reasons.

Some participants changed their focus between the first interview and the second:

I would like to fill my time in the day and in the night more than I do now, make it more . . . worthwhile, the hours go by, projects and stuff, fill them up with that. I would like to sell things I make; I think people would be interested. I've made some nice things . . . and I've given them to my family and they love it, they hang it on the wall and display it and they like to look at it. So that is why I think people would be interested in the things I made. So if I could sell that, I could make a little bit of money and have a little

more money to enjoy myself, go to the mall or downtown or something.

Maybe working in a restaurant, as a bus person or something . . . I would like to do that. Something like [name of restaurant] . . . I loved working there. I had great bosses. I enjoyed myself there so much. So if I could get another job like that I'd be so happy. Because he knows me well, so he knows what kind of worker I was. And he always would come and praise me on my work, so I felt great . . . I was doing a good job and I felt I was an asset to his company.

DISCUSSION

We used an approach grounded in the sociological concepts described by Fine (1992), Giddens (1984), and Goffman (1983) to examine the creation of a self-authored community. The basic premise is that relationships develop as individuals attach meaning to their encounters with others. These encounters depend on certain interactive conditions such as where and when the relationship takes place and the “rules” and “resources” attached to those conditions. Rules and resources are understood in terms of the actions that are possible in a particular context and the systemic limitations of those actions (Fine). Thus they are dynamic, simultaneously enabling, and constraining interaction. Individuals in the encounter are aware of the norm but are flexible, so that an alternative response is readily available (Beal, 1999). This fits with the idea that relationships are, by nature, dynamic. Relationship development occurs in every encounter and its outcome depends on both parties to the encounter (Baxter & Montgomery, 1996, p. 78).

The results of the present study illustrate the challenges faced by those with severe and persistent mental illness in forming relationships and friendships. However, we argue that the processes they use are similar to those used by anyone who has lived in or frequented one place for a long period. The process of forming a social network begins cautiously,

with few expectations. The conditions for venturing forth and connecting are closely related to place—the place where one lives, places in the community such as parks or designated smoking areas where one can connect—and facilitators. All of the participants had recently been discharged after a long hospital stay and were relocated in neighborhoods within a large city. It was evident that those participants who were interviewed a second time had begun to connect. This was because there were many opportunities for them to venture forth, either within their place of residence or in their environment (parks, stores, coffee shops, or at community activities related to eating). Such environments require little interaction and feature the presence of other people. Early, low-key interactions and time-limited connections are important building blocks in the slow construction of a network. Further, it is interesting to note how virtual relationships are constructed and can lead to actual relationships. Virtual relationships may help to lay a foundation for expected behaviors and facilitate venturing forth and connecting, providing a framework for hope and confidence.

In terms of interactive opportunities provided by facilitating factors, the participants clearly illustrated that they understood the reciprocal nature of relationships. Families were not unduly burdened. Participants were able to distinguish between family relationships and self-authored relationships. Family was always considered important, providing a sense of dependability, safety, and security. The participants indicated that they thought about reciprocity in terms of both not being a burden to family and bringing something to the relationship—physically, financially, or in terms of material goods such as cigarettes. Facilitating objects, such as coffee or cigarettes, provided a ready-made excuse to interact and were part of not only the “residence” but also the dynamic of the interaction.

Further, the importance of relationship building and the need to feel that one is a productive member of society was evident. It is in-

teresting to note that the participants were concerned about being demanding or burdensome, indicating that they clearly understood the bi-directional nature of relationships. This finding is consistent with the results of previous research (Beal, 1999).

There is a disparity, however, between the present findings and those reported in the literature concerning the connection between the relationship network and staying out of hospital. The participants clearly indicated that community tenure was not dependent on their friendships or their relationships with family members. As noted above, this sample is relatively small and needs to be treated with caution. However, the importance of supportive relationships, in all their many forms, as noted by Wallerstein (1986) should not be underestimated. The participants saw their relationships as connecting them to the wider community and giving them hope, without necessarily being connected to their staying out of hospital. This disparity also may be related to their relatively short tenure in the community and to an understanding among those with a chronic illness that hospitalization is a necessary and integral part of treatment.

The participants hoped that they would develop more profound relationships and would eventually give up their imaginary companions and participate more fully in an interactive life. They hoped for a good boss, a better figure, more money, and an opportunity to live and work among others.

We argue that venturing forth and connecting is a useful concept when considering how to assist individuals with long hospitalizations to connect to a community. We noted that among our participants there was a will to get out, that they looked for facilitating environments, they used past experiences which gave a comparative context and linked to hope, and they looked for others with whom to connect. Some of the subjects seemed to be beginning to want to venture further forth and establish greater connections. Further research is warranted to assess whether such rudimentary successes in venturing forth and connecting lead to developing the confidence

to venture into increasingly more challenging situations, such as volunteer or paid work, and to endeavor to form increasingly complex relationships, such as close friendships or intimate relationships. Identification of facilitators in such increasingly complex settings would be helpful to both clinicians and individuals themselves as they learn about these processes. We feel there would also be value in replication of the study in a non-urban environment to determine whether the processes

of venturing forth and connecting in rural settings are similar or different from those found in this study.

These seemingly insignificant efforts must be given more credence by professionals in terms of what they mean to the individual. We believe that the activities of people recently discharged from long-term care should be seen as relatively normal ones and as part of the struggle we all face in living in the world together.

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