Making connections: Severe mental illness and closeness with other people

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ABSTRACT

Much has been written about social lives of people with severe mental illness (SMI). Before social lives can flourish, however, people with SMI must first get close to other people. We studied this closeness by holding three, hour-long focus groups at Fountain House, a community mental health agency in New York City. We found that closeness between two people with SMI is challenging because someone with depression, for example, may have trouble understanding someone with a different disorder (e.g., schizophrenia). Romantically, closeness is also challenging—SMI is hard to explain to partners. In the workplace, closeness is difficult because SMI can alienate coworkers. It could push them away. In mental health programs, we found that closeness has more of a chance to develop (1) during evening and weekend activities; (2) when activities are planned often enough to prevent isolation; and (3) when staff reach out to people before extended absence causes distance.

KEYWORDS

Closeness; community mental health; severe mental illness; isolation; depression; mental health; psychosocial intervention; social support

Introduction

Much has been written about the social lives of people with severe mental illness (SMI; e.g., Biegel et al., 2013; Brunt & Hansson, 2002; Burger & Buskens, 2009; Calsyn & Winter, 2002; Goldberg, Rollins, & Lehman, 2003; Goldberg et al., 2003; Hendryx, Green, & Perrin, 2009; Kogstad, Monness, & Sorensen, 2013; Pernice-Duca, 2008; Pernice-Duca & Onaga, 2009; Perry, 2012). Such research focuses largely on social life description (e.g., number of close relationships). However, very little information is available on factors that help people with SMI to find and develop close relationships in the first place. What processes foster or hinder the development of different types of close relationships? Before a social life can flourish, however, people with SMI must first get close to other people. We studied this closeness.
Some research on the topic exists (e.g., Foster, 2005; Gilles, James, Barkhi, & Diamantara, 2007: Hasan, 2012; Lewis, Parra, & Cohen, 2015; Perry, 2012; Priest & Woods, 2015; Roberts & Dunbar, 2011; Tyler & Melander, 2011). Closeness is promoted by proximity between two similar individuals. It tends to begin when people are introduced to each other, when people keep running into each other by chance, or even when a simple greeting is offered (e.g., “hi”). Prior information or observation of the other person helps. In addition, closeness is fostered by repeated time together, particularly when there are short durations between planned face-to-face contacts. Ongoing time together is more likely when two people enjoy each other, or when two people help each other to address problems in living (e.g., job or housing loss; lack of resources). Furthermore, closeness flourishes especially when: (1) advice is offered; (2) comfort is provided; (3) shared understanding takes place; (4) mutual listening occurs; or (5) benefits are reciprocated. It also helps if people outside of the relationship support the connection. Some relationships are discouraged. Finally, closeness can grow if there is the right amount of time (e.g., freedom from work responsibility) and if necessary resources are available (e.g., money for dinner or a movie). Closeness can end when disrupted by circumstance (e.g., housing relocation or job loss).

An older body of research (e.g., Berscheid, Snyder, & Omoto, 1989; Clark & Reis, 1988) defined closeness as a high degree of interdependence between two people (e.g., in romantic partnerships or friendships) who share frequent encounters (e.g., everyday; weekly) over long durations of time (e.g., one year; five years). The two people must influence each other, and they must share diverse activities (e.g., watching television together; visiting mutual friends). Berscheid and colleagues (1989) introduced a questionnaire on closeness (the “Relationship Closeness Inventory”), but it performed no better than subjective measures.

We used systems theory to provide context for understanding how people with SMI get close to others. From a systems perspective, individuals with SMI get close to others within larger contexts or macrosystems. Some macrosystems (e.g., schools; workplaces) may not embrace people with SMI in the same way that they embrace people without SMI, and then closeness is difficult. If macrosystems hamper closeness, then individuals on a micro-level become isolated and disconnected.

Within this systems perspective, getting close to others is especially rewarding when it helps minimize harms of inhospitable macrosystems. For example, Tyler and Melander (2011) suggest that homeless youth can better defend against hostile people or environments (inhospitable macrosystems) after they get close to others in places such as streets or shelters. Likewise, if people with SMI form close relationships in places such as schools or jobs, then they may be better able to defend against hostility or other adverse reactions relating for instance to stigma.

Among people with SMI, we studied the process of forming connections with other people.
Method

We held three hour-long focus groups (N = 20) at Fountain House, a community mental health agency in New York City. Founded in 1948, Fountain House now helps about 1,300 people in New York City to find employment, enhance education, get housing, improve health, avoid hospitalization, and build social networks. It has a model of care that empowers members in unique ways. For example, members are encouraged to socialize with staff even outside of staff workdays, and members participate in the hiring of staff. Its unique approach has now been adopted by hundreds of programs in countries around the world.

We could not collect background information (e.g., gender; race/ethnicity of study participants) in our focus groups. Charts or other sources of information were unavailable to us. Fountain House members simply agreed (voluntarily) to participate in our focus groups on the day of data collection. On that day, with the help of Fountain House staff, we recruited people to be in our study. Some people arrived late for the three groups and some people left early. Generally speaking, there were approximately equal numbers of males and females, and study participants were racially diverse. As in the broader Fountain House community, people in our focus groups had schizophrenia, bipolar disorder, and major depressive disorder, and about half had co-occurring substance use disorders. We stopped collecting data after three focus groups because many of the same themes and patterns started to reemerge.

In order to collect data, three of the authors together facilitated each of the three focus groups. We audio-taped and transcribed each group. The hour-long groups centered on ways that people with SMI get close to others and form relationships in regular encounters (e.g., daily, weekly, biweekly, monthly). Relationships included friends, romantic partners, people at work or school, and people in mental health programs. These categories overlapped, and they did not include all types of relationships, but participants discussed these four types most frequently. We excluded family relations. Based on study participant responses, we concluded that such relations were sometimes immune to personal efforts to get close, or that the closeness had already been established. For some study participants, there was complete distance from the entire family.

Data analysis

In four stages, we used grounded theory to understand focus group themes and patterns (e.g., Lingard, Albert, & Levinson, 2008). In the first stage, one researcher examined themes and patterns in one focus group, a second researcher examined themes and patterns in the second focus group, and a
third researcher examined themes and patterns in the third focus group. We determined that saturation was achieved when the three researchers began to note the same themes and patterns.

In the second stage of our analysis, each of the three researchers examined themes and patterns in all three focus groups. In the third stage, a doctoral student in social work synthesized all of the information into a single document by: (1) grouping together themes and patterns that emerged in all three of the focus groups and (2) creating a taxonomy of the underlying content. In the fourth stage, the first author (a professor of social work) further synthesized the findings.

This process was guided by a seven-stage content analysis (e.g., Hsieh & Shannon, 2005). First, we broke the data apart while categorizing the different concepts. Second, we gained familiarity of the data with repeated reviews. Third, we noted codes of preliminary themes and patterns in the margins. Fourth, we numbered and categorized each code into a classification system. Fifth, we merged together the common themes and patterns. Sixth, we reexamined and related the categories to each other. Seventh, we linked direct quotes to the data.

In using grounded theory to develop our understanding of closeness, we relied on the procedures highlighted by Corbin and Strauss (1990). We looked for concepts that emerged repeatedly in the focus groups, and then we grouped these concepts into larger categories. For example, one concept that emerged repeatedly was the tendency for closeness to develop in evening and weekend mental health care. These extended hours were one of several strategies that mental health programs could employ to promote togetherness, and we therefore grouped this concept (after-hour care) into a larger category (closeness relating to mental health care). Initially, some categories were less developed than others. If categories were poorly developed, then we eliminated them. However other categories, such as closeness in romantic partnerships, contained rich data even though not all study participants volunteered information on the topic. In this case, we went back to the transcripts in order to analyze the data in more depth and detail.

We analyzed the context of our observations. For example, the absence of after-hour care in most other mental health programs underscored the importance of such extended hours at Fountain House. We also analyzed consequences. In the absence of after-hour care, for instance, study participants could isolate at home instead of getting close to others during nontraditional hours.

We revised our hypotheses as our analysis of the focus groups progressed. For instance, we originally thought that people with SMI would be able to understand the symptoms of other people with SMI, and that this understanding would promote closeness. We soon qualified this hypothesis when we realized that some people with one type of symptom (e.g., depression) might not understand people with another type (e.g., hallucinations).
Focus group questions

We first developed a list of 32 questions with separate items for different types of relationships. For example, there were a number of items for friends, a number of items for romantic partners, and so on. We next distilled the list to just a few questions. For instance, one such question was: “What makes it easy and what makes it hard to get close to romantic partners?” In the end, we needed only one question in order to gain in-depth information: “What works well, and what has made it hard to form close relationships?” Use of a single question such as this one parallels the work of others. For example, Roberts and Dunbar (2011) simply asked people to rate how emotionally close they felt toward other people. We obtained Institutional Review Board approval. All authors certify responsibility, and we report no known conflicts of interest.

Results

Friendship

We found that friendship is the cornerstone of getting close. Most study participants reported that repeated interaction helps. As one individual put it, “You see the same people everyday and eventually you start to talk to them and become friends.” Sharing the same activity, where such activity is chosen carefully, was important: “When you initially come for orientation (at Fountain House), they let you visit each unit. I was attracted to the research unit because they all had computers, and everyone looked busy, so I thought this would be the perfect atmosphere for me because I’m not that social.”

Most study participants emphasized the importance of getting close to peers (other people with SMI). There was often a strong bond. For example, a person with depression could relate easily to another person with depression. However, sometimes there was less of a bond when, for example, one person had depression and another had schizophrenia: “At first I thought that people … (with) different diagnoses would be hard to talk to and I would have to be on guard … that someone would harm me. Then I just found out that it wasn’t the case.”

Close friendships to people without SMI (outside of Fountain House) was also challenging: “I couldn’t socialize with anybody outside of Fountain House. They’re too judgmental.” Or, “If your problem is mental illness, (then) there aren’t that many environments where you’ll feel comfortable, or there aren’t many environments where you won’t feel that disconnect between you and other people. It’s one of the things that prevent me from socially interacting.” Several study participants reported that closeness with friends was tougher when SMI and violence were linked in the general public: “You’re like that guy who shot kids in Connecticut.”
In addition, symptoms within a mental illness differed in ways that complicated closeness with others. For example, if sleep disturbance in depression differed from one person to the next, then people responded differently: “Depression will get you with over-sleeping or under-sleeping. … It’s like all these symptoms are not the same in every person, so with social interaction it’s not the same with every person.”

Sometimes, in order to get close to people, participants reported having to learn how to interact more successfully: “I don’t have good social skills and I am only realizing that term now, like I never heard of the term until now, until someone pointed it out to me … I always kind of just hid in the corner.” Self-devaluation was also a factor: “I’ve really got to learn to like myself because my thoughts are toxic, (so) my relationship choices are toxic.”

Taken together, it was hard for study participants to get close to peers if certain symptoms were disconcerting, but it was even harder to get close to everyone else. Repeated interactions helped, as did similarity between people. In addition, closeness was complicated because of the complicated nature of SMI symptoms, and negative self-appraisal or social discomfort was a factor.

**Romantic partnerships**

We found that love relations were critical in getting close. Some participants reported difficulty in getting close romantically: “I hardly talk to women. I always kind of ended up hurt. I think they can smell weakness, like smell it out, and I am a very sensitive person and I think they can play off of that and exploit it.” Other study participants reported being excluded romantically: “I remember years ago during the 1980s I used to go to these nightclubs and I remember people refused to socialize with me. … They called me a nut, a mental patient … (and) the guys threatened me with physical violence if I dated a girl.”

For some study participants, the right type of communication was important, and disclosure was a good idea: “I tell … (romantic partners) that I have mental illness. I’ve had two boyfriends since I’ve had mental illness. They don’t put stress on me. They understand.” At times, it made sense to open up.

Some participants reported that it was easier to develop romantic partnerships with peers, especially if peers were in the same mental health agency: “A short time after I came (to Fountain House) I was talking to women more, I mean there had been other times in my life like in college where I had girlfriends and I was married and I have a son, but there was a little gap afterwards, and then I started talking to women more here, again.”

Some study participants reported that finance was a factor: “If you’re successful, it’s a lot easier … to meet someone else … to have a partner.”
In short, presence of SMI in romantic partnership increased vulnerability, although partnership was less complicated with peers. Self-disclosure was helpful if it was safe, and if it involved mutual understanding. A certain level of socioeconomic status was desirable.

Closeness to people at work or at school

We found that work relationships must be considered. Closeness with co-workers was important, but emergence of SMI was an obstacle: “I had a very positive experience with work before my illness…. I met a lot of people … but then manic depression, bipolar, came in to the picture.”

Study participants reported difficulty in maintaining healthy relationships with co-workers or bosses, especially those who appeared to hold bias against SMI. One participant said that his “last boss was sick. He thought he was Napoleon. He thought that going to see a therapist, getting outside help, was an act of degradation.”

There were also problems with employment gaps: “I’ve been looking for months now and it’s really, really tough … (People) ask me if I’ve gotten a job yet and it’s like oh god, I haven’t and I’ve got to go through the whole thing of people saying ‘have you gotten a job, have you gotten a job?’ and that adds even more pressure.” Unemployment was hard to explain, especially if there were long intervals between jobs.

If study participants could overcome these obstacles, then work promoted closeness with others: “When I got to meet the nice people who work (with me) … I felt really confident … because … (work) is what you do a lot of (the) time … and I was making friends with normal people who weren’t consumers.”

But work could have little effect on closeness, according to some study participants, especially in workplaces that were unsocial more generally: “I really didn’t develop friendships other than knowing employees names … (or saying) good morning or good night…. (It) really wasn’t that friendly.”

Closeness in jobs was comparable to closeness in schools. Some study participants suggested that classrooms could make it easier to get close to others: “I took Spanish. That’s where I made my friends because we practiced speaking Spanish before the class started. … When you’re in a classroom and everyone’s laughing together, it kind of brings everyone a little bit closer together and people are a little bit more social.”

Taken together, study participants reported that closeness was challenging at work when SMI was seen as a weakness, when SMI alienated people at work, when SMI made work difficult, or when gaps in employment were hard to explain. Nevertheless, both workplaces and schools offered opportunities in many cases to get close to other people.
Closeness to people in mental health programs

When study participants compared experience at Fountain House to experience in other mental health care, they discussed four factors that were associated with closeness. First, lack of distinction between Fountain House staff and Fountain House members was a consideration: “(At) Fountain House you can’t even tell the staff from members. … The more you are able to come out of the world of mental disability and rub shoulders with people (without disability), the more you are abled.” Some study participants suggested that closeness with staff at Fountain House increased trust with staff even outside of Fountain House. One participant said that “it brought me closer to my doctors … and I’ve seen more doctors than Woody Allen.”

A second program level factor, staff outreach after absence from Fountain House, was helpful in developing closeness among many study participants. Outreach brought people back to the agency, and this in turn promoted closeness that would have been lost with more absence. One participant said that “I’ve never seen any place where they call you up and are concerned about you showing up,” and another said that: “mental health organizations … (are) just like Vietnam in a way. It’s like a body count.”

A third program level factor, nontraditional hours, helped many study participants to get close to other people: “Fountain House helps me develop friendships … (in) evening and weekend programs … (with) social activities such as parties, and activities like crocheting, watching a movie, board games, karaoke, and dances.” Similarly, one participant had “a special group on Friday nights … (for) making friends … (My group) goes to the diner.” The nontraditional hours increased connection opportunity beyond 9–5 schedules.

Finally, a fourth program level factor, presence of structure, helped to promote closeness in some study participants: “In rigidly structured environments, it was fine with me because my default is not interacting socially. … If it was up to me, if nothing changed, I’d go on isolating myself forever. … The environment here creates a space where there is that opportunity.”

Absence of structure could have the opposite effect: “I have the most trouble socially … (when) there is undefined structure, (and when) intentions are not clear, or there is no concrete … subject to the interaction that binds people.”

Some study participants suggested that flexible structures could work best. According to one participant:

I feel more comfortable socially interacting when there is some amount of structure to the environment but … (not) a definite structure. I’ve developed my (own) structure, where I come in, and I’m comfortable working on certain projects. I look forward to it, and I like it. There are certain things I do. Like work on the newspaper, I edit, as much
as I can, I proofread, I work on the literary magazine. That’s my structure. And most members do that. If they want to, they can create their own structure to whatever extent they want. … I’m comfortable with it. … Just the right amount that will also allow social interaction.

Taken together, in relation to experience both inside and outside of Fountain House, study participants reported that four program level factors promoted closeness. First, it helped when boundaries with staff were unclearly drawn. It decreased power inequalities that caused distance. A second program level factor—evening and weekend activities—increased closeness by increasing connection opportunity outside of regular hours. A third program level factor, outreach by staff after an absence from the program, also promoted closeness. Interruptions from care disrupted togetherness. A fourth program level factor, presence of structure, promoted participation and links between people who might not otherwise get involved. Rigid structure was a dealbreaker, at least according to a few study participants.

**Discussion**

We found that four types of relationships were central to getting close. Friendships, romantic partnerships, connections at work or in school, and social ties in mental health programs were all discussed much more frequently than other types of relationships.

Friendships were critical yet challenging. We found that closeness between two people with SMI was challenging because someone with depression, for example, might have trouble understanding someone with a different disorder (e.g., schizophrenia). The understanding had to be learned over time, at least in some cases. Bonds were often tighter between two people with depression, for instance. Nevertheless, as hard as it often was for two people with SMI to connect, it was even harder for people with SMI to connect to people without SMI. Someone without SMI might associate SMI with violence, for example, or with unpredictable behavior. In agreement with literature on closeness (e.g., Berscheid et al., 1989; Clark & Reis, 1988; Foster, 2005; Gilles et al., 2007; Hasan, 2012; Lewis et al., 2015; Perry, 2012; Priest & Woods, 2015; Roberts & Dunbar, 2011; Tyler & Melander, 2011), repeated interaction helped, as did similarity between individuals.

As in friendship, romantic partnership was complicated by presence of SMI. Study participants with SMI reported that certain symptoms of SMI (e.g., depression) caused partners without SMI to emotionally disinvest. While self-disclosure of SMI was sometimes helpful in building connection, especially if there was sympathetic response, this disclosure was often unnecessary if both partners had SMI. In other words, if SMI was mutual, then there could be mutual understanding between romantic partners, and then
the chances of getting hurt were lessened. This finding on mutuality was supported by existing literature (e.g., Foster, 2005; Gilles et al., 2007; Hasan, 2012; Lewis et al., 2015; Perry, 2012; Priest & Woods, 2015; Roberts & Dunbar, 2011; Tyler & Melander, 2011).

In addition to our micro-level findings on friendship and romantic partnership, we found on a macro level that employment made it easier in some ways and harder in other ways to get close to people. According to some study participants, jobs provided opportunities for closeness, but these opportunities were compromised if SMI emerged. The symptoms could adversely impact other people or cause job loss. It was also hard to explain gaps in employment.

Affiliation with people in mental health programs was complex. When study participants were able to compare experience inside versus outside of Fountain House, we found that lack of distinction between service providers and service users could promote closeness. Closeness with staff, especially staff members who were not bounded by clinical distance found elsewhere, could spread to mental health professionals even outside of Fountain House.

We also found that evening and weekend hours in mental health care could promote closeness by increasing time for interpersonal linkage, much as opportunity for closeness could evolve when staff brought absent people back to programs. Finally, we found that presence of flexible structure counteracted tendency to isolate. Rigid structures, that is, those that were not flexible, were repellent to some people.

Taking together all of the findings, it was a lack of understanding that compromised closeness among people with SMI. The lack of understanding, and the accompanying social distance, was evident when: (1) two people with SMI failed to understand symptoms of SMI in each other; (2) a romantic partner failed to understand SMI in a significant other; (3) co-workers failed to understand SMI, especially when symptoms flourished; and (4) mental health professionals failed to understand SMI in all of its complexity because there was too much professional distance between the service user and the service provider.

However this gap in understanding was bridged when: (1) two people with SMI came to understand each other’s symptoms; (2) romantic partners came to understand symptoms of SMI in the significant other; (3) co-workers came to understand and accept other co-workers with SMI; and (4) mental health professionals came to better understand service users after closing some of the power differential in service provision. Closeness was fostered when these gaps were addressed.

Our study has practice implications. A process in three stages could help people with SMI to get close to others. In the first stage, mental health care professionals could examine closeness to others using a single question. For example, following the lead of Roberts and Dunbar (2011), people could be asked to rate, on a scale of 1–10, their emotional closeness to people in a social network. A social network might include the top five people, for instance, in a social network’s inner circle.
In the second stage, following an assessment of closeness versus distance with others, assistance could be offered to people who have trouble connecting. Such assistance might include four interventions. First, people with SMI in peer-to-peer relationships could learn how to better understand each other and how to better connect with each other. The problem arises especially when one person in a dyad has a disorder (e.g., depression) that differs from the other person in the dyad (e.g., schizophrenia). Second, people with SMI could learn how to better connect to people without SMI. People without SMI often fail to understand. Third, people with SMI could learn how to better cope with SMI in romantic partnerships. Symptoms such as depression, for example, could interfere with the connection. Fourth, people with SMI could learn how to better manage symptoms of SMI in workplaces when such symptoms push away co-workers. Connections in jobs could then grow.

After the first two stages of helping people with SMI get close to others (i.e., assessment followed by intervention), a third stage could ensue. In this final stage, mental health professionals could follow up at later times in order to see if initial efforts to help build closeness have in fact been helpful, or to see if other types of assistance were beneficial. Peers could lead the way in all three stages of closeness development, much as professionals outside of mental health care could lead the way or help.

In short, closeness to other people can first be assessed and then followed up with interventions that promote togetherness. The interventions can target peer-to-peer relationships, relationships between people with versus without SMI, romantic relationships, or work relationships. Mental health professionals can then follow up in order to see if the interventions were effective. In this way, service providers can help reduce social distance. From a systems perspective, reducing this distance can help alleviate SMI-related hardship when macrosystems (mental health program staff, in this case) help people with SMI to develop close interpersonal relationships or links between individuals in microsystems. Such interpersonal linkages can help buffer against distress that may come from symptoms of SMI, for example, or that can come from dealing with stigma or other adverse reactions to SMI.

Mental health programs could build closeness in a number of ways. First, programs could reduce power imbalance. If consumers of mental health care can learn to get close to providers of such care, that is, if consumers learn to get close to providers instead of learning to maintain distance, then perhaps consumers could also learn how to get close to people more generally.

Building evening and weekend availability in mental health care is also a good strategy. It creates more time for togetherness. Consumers could connect beyond traditional 9–5 schedules. Similarly, outreach to people who are absent from programs could create time for closeness. Extended absence promotes distance. Finally, mental health programs could offer
the right amounts of structure. Too much structure may push people away. Too little may not counteract isolation.

Our study was exploratory. The sample size was small, and we studied only one mental health organization with only one type of mental health care in only one urban location. Moreover, Fountain House is unique in many ways, especially because it blurs traditional hierarchical relations, but study participants were nevertheless able to compare experience inside versus outside of Fountain House.

Further investigation is needed. First, closeness between people with different types of SMI, such as schizophrenia versus mood disorder, can complement our focus on SMI more generally. Second, potential differences in closeness can be explored in relation to different numbers of people, such as in dyads versus triads. Third, different standpoints on closeness must be examined. The views of providers, managers, and policymakers could complement our focus on consumers. Fourth, expansion is needed in each of the four areas where closeness is explored, namely in friendships, romantic partnerships, relations in jobs or schools, and relations in mental health programs. Other types of relationships could be explored as well. Fifth, quantitative study is needed in order to complement our qualitative approach.

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