Qualitative Health Research
20(5) 654–667

DOI: 10.1177/1049732310361610
http://qhr.sagepub.com

Conceptualizing Community: The Experience of Mental Health Consumers

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Abstract

In this article we describe a focus group study of the perspectives of diverse groups of mental health consumers on the concept of community. We identify the core domains that constitute the notion of community, and commonalities and differences in the perception of community along the lines of ethnicity and sexual orientation/gender identity. Seven focus groups were conducted with a total of 62 participants. Transcripts were analyzed using the grounded theory approach. Two domains—togetherness and community acceptance—emerged as common to four types of communities that were most frequently mentioned in the focus group discussion. Our findings show that identities other than those associated with mental illness and the role of service user are critical to the understanding of the psychological sense of community among persons with psychiatric disabilities. We suggest that mental health providers empower consumers to expand their "personal communities" beyond that of mental health clients using their diverse identities, and design interventions for addressing the stigma emanating from identities that are discriminated against by the wider society.

Keywords

ethnicity; focus groups; mental health and illness; sexuality; social identity; stigma

Although community integration is a paramount principle, value, and goal of contemporary mental health policy and services in the United States (Carling, 1996; Fellin, 1993; Flynn & Aubry, 1999), there is little empirical work on what community means to psychiatric consumers apart from their physical presence in the neighborhood and their involvement in mental health treatment communities. This is in spite of advances in the social science disciplines in expanding the conceptualization of community to include formal and informal groups that are nonplace-based and are centered on common interests, attributes, and issues of group members (Fisher, Sonn, & Bishop, 2002). In the field of mental health research, we found that personal characteristics such as ethnicity, sexual orientation, and religious faith are essential to the identity of individuals with psychiatric disabilities (Bussema & Bussema, 2000; Harris & Licata, 2000). These attributes might affect an individual's community involvement because groups and organizations differ in their receptivity to persons whose characteristics diverge from those that are considered mainstream.

One avenue to understand community integration is to explore the ways in which persons with psychiatric disabilities construct their experiences interacting with other community members. However, despite the potential influences of social and cultural forces and environmental dynamics on integration (Harris & Licata, 2000; Wong & Solomon, 2002), researchers to date have not explored the commonalities and differences in the conceptualization of community among subgroups of mental health consumers with different cultural backgrounds. We seek to contribute to existing knowledge by exploring the concept of community grounded on consumers' experiences and perspectives. Findings from this study have the potential for informing intervention strategies to promote the recovery of persons with psychiatric disabilities through participation in the communities that they choose.

Background

Community Integration in the Postdeinstitutionalization Era

Central to the notion of community integration is the achievement of parity between persons with psychiatric

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disabilities and their nondisabled neighbors as members of a community. Community integration includes the engagement of persons with psychiatric disabilities in social interactions that take place within normative settings (Wolfensberger & Thomas, 1983) and equal access to social, legal, political, and economic opportunities that are accorded to other members of society (Aubry & Myner, 1996; Prince & Prince, 2002). An integrated community is envisioned as one that is inclusive and accepting, characterized by nondiscriminatory treatment of persons with psychiatric disabilities (Taylor, Biklen, & Knoll, 1987).

The focus in prior research on integration has been on the neighborhood experiences of mental health consumers (Aubry & Myner, 1996; Boydell, Gladstone, Crawford, & Trainor, 1999; Wong, Metzendorf, & Min, 2006) and the identification of personal capacities needed for social connectedness in the context of mental health services (Ware, Hopper, Tugenberg, Dickey, & Fisher, 2008). The emphasis on locality-based communities emanates from the traditional approaches in planning and developing mental health services, "which have defined community exclusively in terms of residential location" (Fellin, 1993, p. 58). By limiting the definition of community to spatial phenomena, researchers have overlooked the potential significance of nonplace-based communities to the lives of psychiatric consumers. In a study of group and organizational involvement of psychiatric consumers living in independent housing with support services, Wong, Nath, and Solomon (2007) documented that a minuscule proportion of study participants (4% of the sample) was involved in any neighborhood or block associations and that 31% were involved in one or more groups and organizations within walking distance from the study participants' homes.

Although involvement in treatment communities such as psychiatric rehabilitation facilities and consumer-run drop-in centers can be critical to building skills and competence essential for the engagement in social interaction in normative settings, a predominant focus on these communities might reinforce a commonly assumed view of persons with psychiatric disabilities as socially isolated and separate from the general population. Researchers have found that friends and acquaintances, including those without a psychiatric history, comprised a significant portion of mental health consumers' social networks (Goering et al., 1992; Lee, Matejkowski, & Wong, 2009). These findings point to the importance of examining the sense of community outside the context of mental health services.

In his critique of the predominantly geographic definition of community-based mental health care, Fellin (1993) recommended that mental health professionals plan programs and individual treatment goals by recognizing the "multiple communities" to which patients belong, and by formulating integration goals in reference to each individual's "personal community." The study described here is in keeping with Fellin's suggestion by broadening the focus of community beyond that of neighborhood and mental health treatment programs.

Conceptualizing Community

Hunter and Riger (1986) listed three heuristic dimensions that have been identified as common in most conceptualizations of community. These dimensions are (a) community as a functional unit meeting sustenance needs; (b) community as a unit of patterned social interaction; and (c) community as a cultural-symbolic unit of collective identity (Foley, 1952; Hunter, 1975). The notion of community as a cultural-symbolic unit of collective identity is tantamount to a psychological sense of community, proposed by Sarason (1974) as an overarching concept in community psychology. McMillan and Chavis (1986) further identified four conceptual components of a psychological sense of community, namely membership, influence, integration and fulfillment of needs, and shared emotional connection. Moreover, the symbolic interactionist perspective in sociology, which emphasizes the role of interaction with others in the development of the social self and the significance of shared conceptions of social reality, can be applied to explore the meaning of community from the perspective of persons with psychiatric disabilities (Hunter & Riger, 1986; Thoits, 1983). According to this perspective, communication networks and information flows deriving from involvement in informal groups and formal organizations are instrumental in facilitating social interactions among members in the building of various conceptions of community (Hunter & Riger, 1986).

The characterization of community as a collective cultural-symbolic unit also suggests a consensual view of community consisting of a group of individuals that is clearly distinguishable from other groups, with community members forming bonds of trust, solidarity, and mutuality based on their commonalities. This conception of community has been criticized for its lack of reference to diversity, dissent, and conflict; for overlooking differences among community members; and for overemphasizing the convergence of goals and purposes within a community (Wiesenfeld, 1996). Specific to the field of psychiatric disabilities, there is empirical evidence on the experience of social rejection and feelings of estrangement among consumers in their neighborhoods and relational communities (Boydell et al., 1999; Bussema & Bussema, 2000). Researchers' lack of awareness of both positive and negative experiences of community

might lead to the omission of important domains that are critical to the attainment of community membership.

Multiple Identities and Experience of Community

The part that multiple identities play in an individual's psychosocial well-being is relevant for exploring the conceptions of community among persons with psychiatric disabilities. According to the "identity accumulation hypothesis," the more social identities that an individual possesses, the less psychological distress he or she will experience (Thoits, 1983). The relationship between multiple identities and positive mental health outcomes is attributed to a sense of certainty and purpose accorded by stable rules of conduct that are derived from reciprocal relationships within a multiplicity of role sets. Not surprisingly, the social roles examined in research that has supported the identity accumulation hypothesis are those that are considered socially valued, including spouse, parent, employee, and student organizational member (Thoits, 1983).

As levels of illness severity and accompanying social and instrumental disabilities fracture over an individual's life course, persons with psychiatric disabilities are often bereft of valued social roles that can contribute to their well-being. More often than not, mental illness gives rise to role loss, which in turn affects individual identity. Being a mental health consumer is perceived as an overarching "master status" (Hughes, 1945) that can result in a "spoiled identity," which is associated with discrimination and social rejection (Goffman, 1963/1974). Indeed, as a response to public stigma (Ekeland & Bergem, 2006), individuals with psychiatric disabilities might choose to selectively reveal or conceal their mental health problems to become included in a majority grouping (Goffman, 1963/1974; Hall & Cheston, 2002). The researchers of a qualitative study of mental health patients in rural communities found that individuals who distanced themselves from their identity as mentally ill patients were more burdened by stigma, had more conflicting-identity experiences, and developed uneasy relations with service providers (Ekeland & Bergem, 2006).

Despite increased attention to culturally and ethnically diverse groups and culturally competent provision of services in the mental health field (e.g., Abrams, Dornig, & Curran, 2009; Lum, 2007; Sue & Sue, 2003), few researchers have drawn attention to the role of multiple identities in the lives of people with psychiatric disabilities. Findings from a recent study on identity maintenance strategies employed by people who attended a drop-in center raised questions regarding the prevailing assumption of the salience of mental illness as a marker of personal identity (Hall & Cheston, 2002). Specifically, Hall and Cheston found that "[m]any people who used the drop-in made it quite clear that they did not identify with or want to mix with other service users who appeared to be more deeply affected by their illness and less integrated in society than themselves" (p. 38). In addition, the authors highlighted the perceived differences in identity among center members along the lines of gender, ethnicity, and sexual orientation. Focusing on the treatment experience of psychiatric patients who are also sexual minorities, Harris and Licata (2000) pointed out the problem of recognizing only an individual's psychiatric needs without acknowledging other aspects of personalities, such as cultural background and sexual orientation. Psychiatric patients with alternative sexual orientations or gender identities are susceptible to the "double stigma" of ostracism by society at large because of their sexual orientation or gender identity as well as their mental illness status.

Purpose of the Study

Research conducted for this article was premised on a social constructionist view of community. Along the lines of a prior conceptualization by Hunter and Riger (1986), we consider community "not a received truth, something out there to which individuals simply relate; rather, a community is what people define it to be" (p. 64). Accordingly, we began this study with an open mind toward what community is, leaving space for consumers to construct it on their own. The literature that we have reviewed sensitized us to the salience of identity and, in particular, multiple identities and stigma within the framework of symbolic interactionism. We discuss the theories and concepts that turned out to be relevant after we present our findings.

The purpose of this research was to explore conceptions of community held by persons with psychiatric disabilities. Noting the multiplicity of identities in people's lives, we adopted the notion of low-status minority grouping (Hall & Cheston, 2002). Low-status minority groups are groups that possess characteristics considered to be negative by the majority of society. Specific to this study, we examined persons with psychiatric disabilities from ethnic and cultural minority groups including the lesbian, gay, bisexual, and transgender (LGBT) communities. The present study was designed to address the following research questions:

1. What are the core domains that constitute the notion of community from consumers' perspectives?
2. What, if any, are commonalities and differences in the perceptions of community among subgroups of mental health consumers of

different ethnicities, sexual orientation, and gender identities?

Methods

This was a qualitative study in which we used a grounded theory analytic approach (Strauss & Corbin, 1998) to examine constructions of community by mental health consumers. The primary method of data gathering was through focus groups.

Sampling and Recruitment for Focus Groups

The sampling goal was to form focus groups of mental health consumers who had the potential of expressing different cultural perspectives. We recruited 5 groups that were culture-specific and 2 that consisted of consumers in similar or identical living situations. Consistent with the advice of Morgan (1997), we overrecruited with the goal of achieving a focus group size of 6 to 10, recognizing that these parameters were flexible.

Initially, the first author sought advice and help with recruitment from behavioral health providers whom she knew from prior research on housing, and from an expert on the lesbian, gay, bisexual, and transgender community. Based on the information and recommendations she obtained from them, seven focus groups were formed. One consisted of 13 Latinos/Latinas who were in an ethnic-specific day treatment program. Another (n = 9) was a Cantonese-speaking group of consumers at a community mental health center. An additional Asian group comprised 8 individuals who spoke five different languages and were at the same mental health center. (Interpreters were present at this session.) The mental health program from which the two Asian focus groups were recruited served diverse linguistic groups that were mostly first-generation immigrants. Interpreters were routinely used in the provision of care, including group meetings and activities, making focus groups a viable data collection method for learning about participants' perspectives on community. The fourth group was composed of 11 individuals who identified as lesbian, gay, or bisexual (LGB). This consisted of members of a preexisting peer support group and a program for persons with serious mental illness who were also diagnosed with HIV/AIDS. Most of the members of a separate transgender (T) group (n = 11) were transwomen (biological males who identify as female or transgender) and were also in a program for persons with mental illness and a diagnosis of HIV/AIDS. Two individuals participated in both the LGB and T focus groups. Members of the sixth group (n = 7) resided in a group (congregate) residential care (RC) facility, and those in the seventh group (n = 5) lived in a scattered-site supported independent living (SIL) program.

Procedures

Focus group meetings took place in conference or program rooms at community mental health centers, psychiatric rehabilitation centers, or residential programs. All participants signed informed consent forms in English, which was approved by the authors' university institutional review board (IRB). We also applied for and received approval of the study protocol from the city's department of public health IRB because the study involved users of community mental health services. For those who required it, interpreters translated the forms orally into their language. After completing the consent process, participants were given a short questionnaire on their sociodemographic characteristics and group and organizational involvement. Those who were able to read and write in English completed the form themselves. Interpreters or the first author completed the form for those Asian participants who were not literate in English. Participants were also asked on a different form to indicate the neighborhood in which they lived. For all but the LGB and T groups, participants signed an authorization form permitting the research staff to contact their mental health provider about their psychiatric diagnosis. Participants of the LGB and T groups, who were not recruited through a mental health facility, were asked to self-report their psychiatric diagnosis on another form. The focus group meetings took approximately 1.5 hours.

Five of the seven focus group meetings, including the one with Latinos/Latinas, were conducted in English by the first author, with the third author observing and taking notes. The first author facilitated the Cantonese-speaking focus group in Cantonese. She conducted the other Asian group in English, with case managers from the community mental health center translating English into five different languages and then translating their responses into English. All focus group meetings were tape recorded and transcribed, with an independent agency transcribing all the tapes but the Cantonese one. The Cantonese group meeting was transcribed by a native speaker and then translated into English by a specialist in Chinese. To check for accuracy, the first author, who is a native Cantonese speaker, also transcribed the discussion. For the meeting conducted in several Asian languages, only the English portion was transcribed by the independent agency. For the five non-Asian groups, notes of the third author were compared with the transcriptions. This helped clarify missing words in the transcripts.

Focus Group Protocol

The focus groups began with the facilitator thanking members for participating, explaining the purpose of the group, and putting forward the ground rules (e.g., "Speak up and try to talk one at a time"). Group members were then asked to introduce themselves and, in the case of the immigrant groups (i.e., Latino/Latina, Cantonese, and Asian), to state where they were born and when they came to the United States. Next participants were asked to answer warm-up questions.

Questions were then asked about participants' involvement (a) in groups and organizations and (b) in their neighborhood and with neighbors. Specifically, the facilitator read a list of possible group/organization types to make sure that participants included them on the group/organization form. The group/organization types mentioned were (a) groups in neighborhoods; (b) church, synagogue, or mosque; (c) groups for people experiencing the same illness or sharing similar concerns (such as mental health treatment, 12-step groups, or support groups); (d) groups for people coming from the same country or culture, or sharing the same language; (e) groups in the workplace; and (f) groups for people with the same sexual orientation or gender identity. Follow-up questions had to do with what belonging to these entities contributed to participants' feeling a part of or not feeling a part of the community and how these entities could be improved. These questions included (a) Do you consider (name of group/neighborhood) your community? (b) What makes you feel you are part of the community in (name of group/neighborhood)? (c) What kinds of things get in the way of your being or feeling part of the community in (name of group/neighborhood)? (d) Tell us about things that could be improved to make (name of group/neighborhood) a better community for you; and (e) What makes you feel (name of group/neighborhood) is a good (or not so good) community? A concluding question elicited additional thoughts about community.

There were some minor differences in questions asked of the Asian participants. For example, the warm-up questions for all groups but the Asians were (a) There are many kinds of communities that people belong to. Would you tell us what you consider to be your community or communities? and (b) When you hear the word "community," what thoughts come to your mind? The parallel question for the Asians was "What do you like to do in your leisure time?" The reason for this change is that most of the Asian participants were Chinese and the Chinese lexicons do not have everyday words that are the equivalent of community. In addition to this difference, only the non-Asian groups were asked to write down the names of groups and organizations that they had joined. The facilitator elicited names of groups and organizations that members of the two Asian groups joined during the focus group sessions because most members of these two groups did not write in English.

Data Analysis

Data analysis of the transcripts followed the grounded theory approach, in which codes become increasingly conceptual with each step (Strauss & Corbin, 1998). Initially, the first author reviewed and created "open codes" for all seven transcripts while the second author engaged in a similar procedure with three transcripts. Subsequently, we reviewed the three transcripts that we had both coded and agreed on nomenclature for "axial" coding of all the transcripts. Next, the first author reread and recoded all the transcripts following the codes that we had developed together. A qualitative computation software package was used for data management and coding. Subsequently, the second author reviewed all the codes and corresponding text units to ensure consistency with the coding system and meanings of codes. Next, "selective codes," representing domains that were apparent in the codes and text units, were created. A concept map linking the types of communities with the domains was constructed.

During the course of data analysis, the authors wrote memos on the concepts, themes, and domains that were emerging. We met regularly to discuss the emerging findings. In addition, we triangulated data from the focus group transcripts with the written responses in the brief questionnaires and lists of groups and organizations to check for consistency and to identify the multiple identities of participants. We considered the characteristics of participants' neighborhoods in interpreting the text units pertaining to neighborhood. This enabled us to contextualize what was said in the focus groups.

Limitations

Several considerations must be kept in mind when interpreting the findings derived from this study. First, we offer a caveat related to language. Although the inclusion of multiple ethnic–linguistic groupings enabled us to hear about the experiences of service users who are not often included in other studies, important themes or cultural references might have been "lost in translation." In a broader sense, we also noted the possibility of "linguistic disparities" across focus groups, with members of some groups expressing their experiences more eloquently than members of other groups. Second, we acknowledge that we seek transferability rather than generalizability (Lincoln & Guba, 1985). Accordingly, the findings are

applicable to contexts that are similar to the one in which this study was undertaken, that is, urban environments in which individuals with mental health problems of diverse cultures use formal treatment programs or peer support groups. Third, we recognize that the findings reflect the subjective experiences of study participants and the cultural communities about which they spoke.

Results

Characteristics of Study Participants

The sample of 62 participants in the seven focus groups comprised more men (65%) than women, with a wide age span of 27 to 75 years, and an average age of 44 years. Overall, the sample was diverse in relation to race/ethnicity, education, psychiatric diagnosis, sexual orientation/gender identity, religious preference, country of origin, and length of stay in current residence. About 30% of the sample identified as Black/African American, one quarter Asian, another quarter Hispanic, and the remainder White or other. More than one third had less than high school education and another third had graduated from high school, with others having at least some college, if not a graduate degree. Specific to psychiatric diagnosis, the groups varied in the portion of participants with a diagnosis of schizophrenia, ranging from all in the RC group, about two thirds in both the Latino/Latina and Cantonese groups, one half in the Asian group, 40% in the SIL group, 9% (1 participant) in the T group, to none in the LGB group. The majority of other psychiatric disorders were major affective disorders. Almost a third of participants identified their sexual orientation/gender identity as LGBT. Nearly two thirds considered their religion to be very important, with their religious preferences being Catholic, Protestant, Muslim, Buddhist, Mormon, Christian Scientist, and Quaker, with a few having no preference. Places of origin were mainly Asia and Puerto Rico, if not born in the United States (53%). Those born outside the United States had lived in this country from 3 to 53 years, with an average of 21 years. About one third of the study participants lived with family members, with only a few living with a spouse/partner or children. The sample members' living arrangements were relatively stable, as the length of stay in their current residence was on average almost 4 years, but the range was from 1 month to 27 years.

Concept Map Delineating Domains by Types of Communities

The results of this study are represented in Figure 1, a concept map. The rectangular blocks in the map specify four types of communities that were most frequently mentioned in the focus group discussion. These include (a) communities based on shared cultural identities including ethnicity, sexual orientation, and gender identity; (b) communities comprised of people who were experiencing mental illness or sharing similar health concerns (including substance use issues and HIV/AIDS); (c) communities based on shared faith traditions; and (d) neighborhood as community. In the following analysis, these four types of communities are called, respectively, cultural identity, treatment community, faith community, and neighborhood. With the concept map we depict nine distinct conceptual domains (identified in elliptical circles) that derive from participants' discussion on these four types of communities.

Two domains—*togetherness* and *community acceptance*—were reflected in all four types of community. Accordingly, we consider these to be core domains. Domains that were unique to specific community types are *identity disclosure* in cultural identity; *wellness management* and *activities* in treatment community; *guidance* and *sanctuary* in faith community; and *neighborliness* and *quality of life* in neighborhood. We begin our presentation of findings with the core domains.

Togetherness and Community Acceptance as Two Core Domains Underlying the Notion of Community

Togetherness. Study participants described togetherness as membership, a way to make a contribution, and a means to reciprocity. Of these characteristics, membership appears to be the basic component of the domain of togetherness. To participants, membership refers to being with others like themselves who have had comparable life stories and thus "you don't have to explain yourself" (Mike, LGB; note that pseudonyms are used throughout this article). When participants are with others who have similar ethnicity, sexual orientation, mental health issues, and other characteristics, they feel comfortable and understood (Martha, RC). Notably, some of these characteristics are held in low regard by the wider community. Several participants described those with whom they experienced community as members of their family. For example, Kay (Asian) described other clients in her treatment setting (all of whom were Asians) as being "like cousins or brothers/sisters," whereas Tara (LGB) described members of her HIV/AIDS program for psychiatric consumers as "a whole other family outside of your regular family." One of the characteristics of family, described by Herbert (SIL), is that "[t]hey never turn their back on you. They're there for you no matter, through thick and thin."

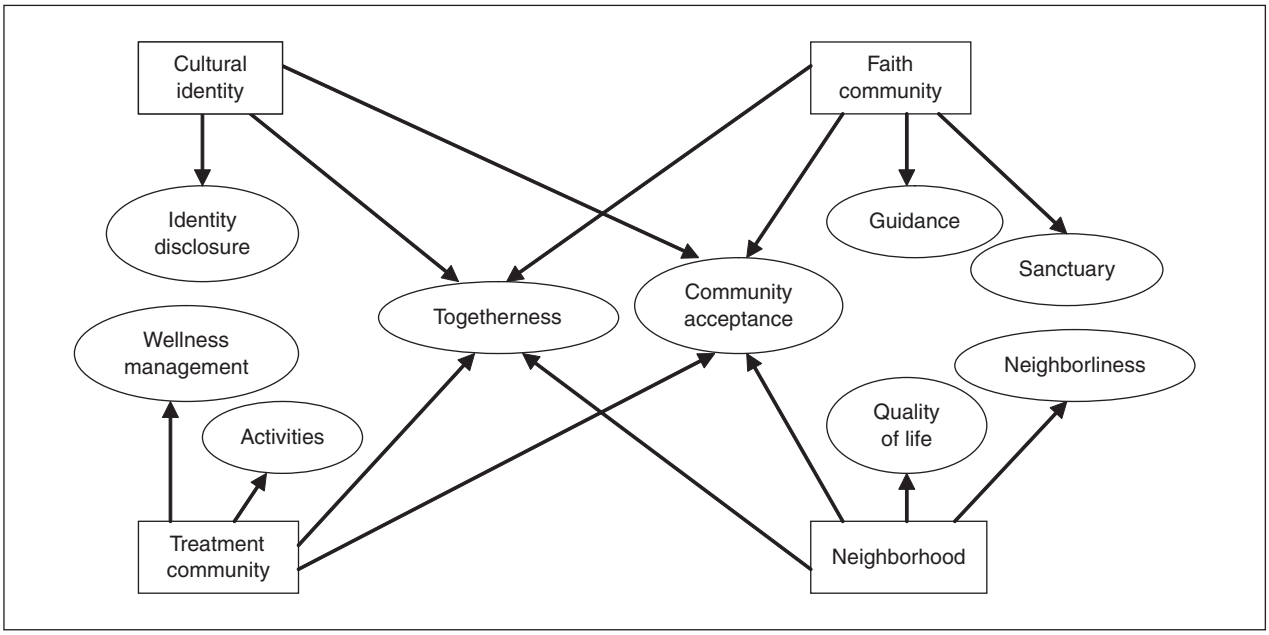

Figure 1. Types of communities and conceptual domains

Similarly, others described membership in terms of friendship. Other clients in a mental health program might be their only friends or augment their circle of friends. Additional references to membership had to do with being connected, belonging, and sharing. For example, George (SIL) said, "We have things in common. Instead of looking at the differences and arguing, we can agree on trying to better ourselves."

Another perspective on togetherness was to focus on making a contribution or performing community service. Participants talked about keeping their neighborhoods clean and safe, advocating for increased funding for persons with HIV/AIDS, and helping their church or temple. As Kong (Cantonese) described his group's involvement in a protest action against a proposal to close a fire station in Chinatown, "We participated in the protest and held placards in Chinatown. The shops posted all the signs/posters about the protest, and some people joined in the lion dance. They beat the gong and the drum." Whereas the focus group participants who were previously described emphasized giving to the community as an aspect of togetherness, others discussed reciprocity, which involves both giving and receiving. Those who discussed reciprocity spoke of giving and taking as an aspect of sharing or wanting to help others out of an appreciation of having been helped. As Jeffrey (LGB) explained, community is "about shared values and goals," but "it's also about each person giving things of themselves to community but also getting some things in return, and I think to the extent that you feel you're not getting something back, that might be [lead you to] move on."

Community acceptance. The second core domain referenced in all community types is community acceptance. Participants spoke about community acceptance and its converse, community rejection. With respect to the former, they expressed appreciation for some settings, such as particular congregations, in which they felt comfortable and understood. In these settings, they were welcomed regardless of their mental health status, sexual orientation, gender identity, race, or ethnicity. For example, Hugo, who is from Puerto Rico and gay, spoke of being told in a neighborhood church that gay people are "going straight to hell," whereas at his current congregation,

> everybody is welcome to have communion and to enjoy in this gathering, this spiritual gathering together and nobody is excluded. My church has a wonderful cause; it's gay people, lesbians, transgenders, kids, straight people, single people, Oriental, Spanish guys, Black people.

Furthermore, participants were pleased to be in communities in which they were acknowledged. As Lauren, a participant in the transgender focus group, explained,

> I just know that like every time I go into a neighborhood, I mean, I know somebody. I mean I know

> a lot of people. And like the majority of them are heterosexuals. And like no matter where I go, I get along with everyone. . . . Everywhere I go someone knows me, you know, and it's like they acknowledge me in front of people.

Participants also discussed their feelings of rejection, discrimination, or being stigmatized. LGB focus group members discussed being ostracized by their families, churches, and other communities during adolescence and in their current neighborhoods. One consumer (Mike, LGB) recalled being taken to a congregation in which "they cast the demon of homosexuality out of me during the service and every Thursday, apparently, they prayed the same thing." Others (LGB group) expressed disappointment with gay doctors for not giving them emotional support or not accepting their health insurance. Residents of the group home (RC) talked about difficulties finding community "outside the psychiatric community," noting that even family members do not accept them, and others do not understand them, because of their mental illness. Transgender focus group members expressed fear of personal endangerment and referred to incidents in which transgender persons were beaten up in their neighborhoods or abused by the police or paramedics. In particular, they discussed the cases of a transgender woman who bled to death because the "paramedics would not touch her when they found out that she was preoperative" and a trans-man "who was raped in his own home by people who were supposed to be his friends" (Donna, T). They also discussed employment discrimination. For example, Joanna (T) said,

> It's hard for us to even try to get a decent job these days. They will say, they'll withhold applications—okay. Applications still on the desk. They say they'll call in two or three weeks. They didn't call. A month done passed, no call. It doesn't make no sense. They should accept us for who we is and what we are. Because we got feelings just like anybody else.

Domains That are Unique to Specific Types of Community

Besides the two domains that were described as common to all four types of communities, seven domains were found to be unique to specific types of community. Identity disclosure is unique to cultural identity, whereas wellness management and activities are unique to treatment communities. The domains of guidance and sanctuary are particular to faith communities; quality of life and neighborliness apply to the neighborhood type of community.

Identity disclosure. Identity disclosure refers to revealing one's identity to others. This domain was mentioned exclusively by participants of the LGB and T groups. As expected, identities such as lesbian, gay, bisexual, and transgender can be stigmatizing, and disclosure of these identities can have negative repercussions. The major themes we found among those who discussed identity disclosure were affirmation, passing, and keeping to one's self. Those who expressed affirmation were open and positive about who they were. As Tara (LGB) said, "I'm who I am. This is what I want to be, how I want to be, [and] I don't try to throw that on anyone else. So that just makes me my individual self." Focus group members expressed pride and a willingness to disclose their sexual orientation at the same time they recognized that others might not accept them.

The transgender participants (all trans-women) used the strategy of reverting to passing as a man when they considered being accepted as a woman to be unlikely. Passing strategies included "blending in, being invisible, and minding one's own business" (Boydell et al., 1999, p. 15). Investigators of a recent study on the disclosure of HIV status noted that "people whose stigma is not visible or immediately apparent can elect to manage the potentially stigmatizing information and attempt to pass as normal" (Greeff et al., 2008, p. 314). As Joanna (T) shared about her experience,

> I was transgender since 16. And just about a year and a half ago I just start[ed]. And I don't feel comfortable. This is not me, but I have to do it today to get by. You know, I have to be someone that I'm not. You know, so I've got to put a hat on, and dress and walk around and say, "Yo, what's up man?" That's not me.

Joanna's experience of slipping back into the appearance of a man is illustrative of the challenges she has faced in adopting a social and personal identity that corresponds to her own gendered self.

Related to the theme of passing, T group participants reported that they kept their gender identity to themselves in order to get by. As Tess explained, "I stick to myself a lot of times because people don't understand. There's a lot of ignorance out there. . . . I can't talk to nobody but case managers, my peers around me, and family, I should say. Basically that's it. I'm just a loner."

Wellness management. Unique to treatment communities, specifically mental health programs, HIV/AIDS programs, 12-step groups, and mental health peer support groups, wellness management refers to attending to needs emanating from study participants' physical and behavioral health problems. Those in mental health programs

spoke about the help they received from attending, talking about their problems in groups or with a therapist, and taking prescribed medication. They reported that mental health treatment had kept them out of the hospital and helped them move into housing. For some, participating in the program provided a means of structuring their lives; for example:

> This program, it keeps my mind kind of occupied because a lot of times I think I'm depressed and I hate to stay home because I feel like I'm enclosed in four walls and I have nothing else to do, so I just come here every day and I gather with the other people and talk. (Yolanda, Latino/Latina)

Those who were in treatment for HIV/AIDS participated in a variety of health and mental health programs. They talked about benefiting from learning about the virus and medication and how to live with the illness. They found support from and were able to connect with other individuals in the same circumstances. Participants in 12-step groups who were in a supported independent living program as well found these meetings helpful. George (SIL) found that observing others in a Narcotics Anonymous group motivated him. After seeing people with many years of sobriety, he explained, "I'd be asking myself, 'Can I do that?' And I said, 'They did it one day at a time' [and] . . . 'If they could do it, I could do it.'" On the other hand, several members of the LGB group reported that they felt uncomfortable in 12-step groups. They were concerned about confidentiality, the "boot camp" atmosphere, and being "preached" to about having to go to meetings to get well. Members of the LGB group who belonged to a mental health peer support group that is exclusively for them expressed positive feelings about it. They received emotional support, advice about medications, and information about benefits from their peers. Participating in the group also offered them support, friendship, and opportunities to socialize.

Activities. Activities are also unique to treatment communities. Participants in the focus groups were clients at psychosocial rehabilitation, day treatment, and other programs in which there were informal and organized activities. They spoke about exercising, playing games, and listening to songs, as well as learning English, going to a clubhouse, and learning skills of independent living. They also discussed activities that took place in the community such as shopping, eating out, going to the zoo, and going to the park.

Guidance. Guidance, or help finding a direction in life, was unique to faith communities. Participants spoke about the church or temple as a place in which one can learn morality, connect with a Higher Power/God through prayer, and be led "to the right way." Several spoke about learning how to be good through the teachings of the Buddha, listening to sermons, singing, and finding truth in the *Bible*. Enrique and Domingo (both in the Latino/Latina group) talked about how going to church "keeps you out of trouble," whereas Herbert (SIL) talked about the moral and spiritual support he receives from "God up above" and the people in his church.

Sanctuary. A related concept, sanctuary, was also unique to faith communities. The word sanctuary has many meanings; here it refers to a spiritual space in which one can find safety, refuge, or uplift. Several participants talked about finding protection and escaping from the negatives through believing in a Higher Power/God. Others described finding peace in their places of worship and spoke about faith as a means for restoration to sanity. Pung Hay (Asian)'s interpreter described the participant's response as a means to fulfill his obligation to his deceased parents:

> He usually bring the foods to the temple during New Year and he burn the incense first and then he pray to his dead parents, that to give them blessing like to make him feel better and not having the mental illness or any medical problems. And he believe that the food will go through the monk into the dead ones.

Neighborliness. Neighborliness is a domain that captures social interactions and relationships of community members who live in close geographic proximity to each other. Neighborliness or the lack of it was discussed a great deal by focus group participants. Many of the positive statements were expressed simply as, "My neighborhood is good," "People are nice to me," "Neighbors talk to me," "They're friendly," and "Everybody gets along well." Other statements depicted cordial yet superficial interactions. For example, Donna (T) said,

> Well, the yes is that they're civil to me. They treat me with respect. I say, "Hi." We have meaningless conversations. And in that respect, I'm part of the community because I live there. And I say, "Hi," and they see me going back and forth into my house. So they know . . . I live on the block. But do they know what movies I like? Do they know what—do they know my favorite foods? Do they know what music I listen to?

On the other hand, some participants talked about more intense interaction, including having coffee or meals with neighbors, forming friendships, and helping each other out. Others, who had minimal interaction with their

Table 1. Common and Unique Domains Specific to Community Types Discussed in Focus Groups

	Focus Groups						
Community Type/Domain	Cantonese	Asian	Latino	LGB	Trans	RC	SIL
Cultural identity							
Togetherness	X			X	X		
Community acceptance				X	X		
Identity disclosure				X	X		
Treatment community							
Togetherness	X	X	X	X	X	X	X
Community acceptance						X	
Wellness management	X	X	X	X	X	X	X
Activities	X	X	X	X	X	X	X
Faith community							
Togetherness	X	X	X	X		X	X
Community acceptance		X	X	X			X
Guidance	X	X	X	X		X	X
Sanctuary		X	X	X		X	X
Neighborhood							
Togetherness	X		X	X		X	X
Community acceptance			X	X	X	X	
Quality of life	X	X	X	X	X	X	X
Neighborliness	X	X	X	X	X	X	X

X = a theme discussed in a specific focus group; LGB = lesbian, gay, or bisexual; Trans = transgender; RC = residential care; SIL = supported independent living

neighbors, attributed the lack of neighborliness to their own or others' lack of interest in interacting.

Quality of life. Quality of life is also a domain unique to neighborhood communities. This concept refers to favorable and unfavorable attributes of the neighborhood that contribute to its desirability as a place in which to live. Those who highlighted the positive attributes discussed their neighborhoods as peaceful and quiet, attractive, and convenient to shopping, religious congregations, transportation, and family and friends. Those who talked about the unfavorable attributes described their neighborhoods as being ridden with crime, drug-infested, and dirty. For example:

> It's very unsafe. . . . After 4:00 p.m. it's a lot of crime. The people, you know, it's drugs and stolen things. . . . Stolen bicycle. And sometimes they chase you to get money. (Hon Luen, Asian)

> My neighborhood years ago used to be nice. . . . Right now . . . there's abandoned houses on the block. (Yolanda, Latina)

People who used to live in better neighborhoods reflected on the difference. Those who appreciated the quality of life in their current location reflected on how favorably it is compared with other neighborhoods or where they used to live.

Commonalities and Differences in the Perceptions of Community Discussed in Focus Groups

We organized all text units reflecting the common and unique domains according to whether or not they were being reflected in the seven focus groups. We constructed Table 1 after categorizing 552 text units derived from the transcripts. Note that there was no discussion on faith communities for the T group because of the constraint of time.

As the patterns in Table 1 show, domains pertaining to cultural identity were reflected in the Cantonese, LGB, and transgender groups only. Moreover, only members of the RC group shared their experiences of "community acceptance/rejection" related to membership in treatment (psychiatric) communities. In contrast, all seven focus groups covered the domains of togetherness, wellness management, and activities under treatment community, and the domains of quality of life and neighborliness under neighborhood. Excluding the transgender group, the domains of togetherness and guidance were considered in all six focus groups under faith community.

As one of two core domains referenced in all community types, the experience of community acceptance (or rejection) was shared far more often among members of the LGB and T groups than the other groups. Most comments from the LGB and T groups were related to

negative experiences, that is, community rejection because of group members' cultural identity as a person with alternative sexual orientation and gender identity in different contexts. Members of the RC group also shared experiences of social rejection by community members (i.e., "community outside the psychiatric community") and family as a result of their mental health consumer status.

Discussion

Despite the importance of community integration as a principle and goal of mental health policy and services, extant studies have not adequately addressed the social and psychological dimensions of integration, including social interactions and engagements with community members, and the perception of community membership (Flynn & Aubry, 1999; Wong & Solomon, 2002). Based on the findings of this focus group study, we offer an understanding of the cultural-symbolic view of community grounded in the experiences of diverse groups of mental health consumers. We approached the topic from the social constructionist perspective, asking groups of individuals who were connected with formal or informal mental health services what it means to belong to a community.

Our analysis indicates that participants with different cultural backgrounds have similar conceptions of community. In addition to their neighborhoods and treatment and support groups, focus group members talked about communities based on shared faith traditions. Excerpts related to the experiences of cultural identity-based communities were derived primarily from discussions in the two focus groups for members who self-identified as LGBT, and to a lesser extent, in the Cantonese-speaking focus group. Members of the Latino group who grew up outside the continental United States simply contrasted their experiences before and after migration or immigration, but did not discuss their experiences based on ethnicity. Because we did not engage in active probing of cultural identity in the focus groups, it is not known if our findings on cultural identity-based communities would be different had we done otherwise.

Two core domains—togetherness and community acceptance—emerged in all four community types that participants identified. Whereas "togetherness" emphasizes a sense of fellowship and solidarity through belonging to a collective body, "community acceptance" addresses the treatment of minority-status individuals within majority groupings, acknowledging the presence of differences, diversity, and dissent among group members (Wiesenfeld, 1996). Similar to McMillan and Chavis's (1986) notion of psychological sense of community, the domain of togetherness captures the conceptual components of membership, a way to make a contribution, and a means to reciprocity. In the domain of community acceptance, study participants described incidents of social rejection, signaling an array of barriers to community integration. In spite of expressed feelings ranging from not being understood to fear of personal endangerment as a consequence of social rejection, participants also developed a sense of belonging to alternative communities in which they were being welcomed regardless of their difference.

The social identities noted by participants in various spheres of community involvement signal the applicability of the symbolic interactionist view of "society as a complex, differentiated but organized mosaic of relatively durable interactions and relationships, embedded in an array of groups, organizations, communities, and institutions intersected by encompassing structures of age, gender, class, ethnicity, religion" (Stryker, 2002, p. 226). According to this view, social interaction is enacted through relatively small, specialized, and sometimes overlapping networks (Stryker, 2002), and is essential to the development of personality or the social self (Thoits, 1983). Despite exclusion from valued social roles, being a mental health service user is not, from the perspective of participants, a "master status" (Hughes, 1945), but only one among multiple identities that an individual possesses (Finlay, Dinos, & Lyons, 2001; Thoits, 1983).

In our findings, we attest to the significance of identities that are based on sexual orientation/gender identity, ethnicity, and religious expression. Among these identities, being LGBT appears to be the most encompassing, as such identity seems to pervade various arenas of social relationships. The salience of the LGBT identity might reflect the highly committed nature of focus group members' relationships to other people with alternative sexual orientation/gender identity across different contexts. However, persons with psychiatric disabilities who also self-identify as LGBT might gravitate toward each other because of their "spoiled" identities (Goffman, 1963/1974; Reutter, et al., 2009) and the multiple stigmas they have experienced—for example, as sexual/gender minorities in faith communities and "second-class" citizens in a sick role with limited resources in the "generic" LGBT community. This supports the value of mental health peer support groups that exclusively serve individuals who self-identify as LGBT as safe havens in which members can find affirmation, protection, fellowship, and stability.

The sense of belonging engendered through participating in a protest action against a proposal to close a fire station in Chinatown is another example of how a status other than that of a mental health consumer emerged as a

salient identity under certain circumstances. The age at which they immigrated to the United States (all but one of the Cantonese focus group members came to this country as adults) and their limited proficiency in the English language might have contributed to a strong sense of belonging to the ethnic enclave, despite the fact that none of the Cantonese-speaking focus group members lived in the Chinatown vicinity at the time of the study. In particular, one participant spoke about his reason for engaging in collective action as "being Chinese": "As Chinese, we should participate in the protest. If they closed the fire station, who is going to put down the fire?" In a similar fashion, members of the Asian focus group spoke about partaking in services and activities in religious organizations (in this case, Buddhist temples) that were established along ethnic–linguistic lines. Apparently, ethnic identity and cultural expression of religion intersect to form an important identity for these study participants by providing meaning, direction, and guidance to their lives.

Our findings are consistent with those of prior research that challenged the notion that people with mental illness accept this status as a key attribute of their self-concept (Camp, Finlay, & Lyons, 2002; Thoits, 1983). Although we did not specifically explore the position of mental illness in participants' self-concept, focus group discussions suggest that sexual orientation and gender identity might be paramount to a person's identity, overriding the identity of psychiatric patient. There were far more references to incidents of discrimination, devaluation, and maltreatment as a consequence of one's sexual orientation/gender identity than any other attributes of self-identity. Indeed, discussions of community rejection based on membership in mental health treatment communities were restricted to the RC group only, which could be interpreted as evidence that congregate housing is a key impediment to community integration for mental health consumers living in such facilities (Wong, Filoromo, & Tennille, 2007).

Findings on the importance of faith communities are consistent with the principle that integration should be within natural communities (Biegel, Tracy, & Corvo, 1994; Davidson et al., 2001; Perese & Wolf, 2005). They are also congruent with recent studies on the significance of religion and spirituality as coping methods or correlates of well-being for persons with serious mental illness (e.g., Corrigan, McCorkle, Schell, & Kidder, 2003; Yangarber-Hicks, 2004). We suggest, based on our findings, that faith communities vary in their acceptance of persons with mental illness and diverse sexualities. Thus, we recommend that mental health providers discuss involvement in faith communities as an option and explain that there is variation among communities in their acceptance of differences. Furthermore, providers can advocate through religious leaders for inclusion of diverse consumer populations.

In a qualitative study on stigma and self-esteem, Camp and colleagues (2002) found that the mental health drop-in center where they recruited their sample played a role in maintaining positive conceptions of study participants' self by providing an accepting and understanding network that was not available outside the center. The researchers also found that although study participants avoided publicly disclosing their association with the center, they did not disclaim their social connectedness with other service users at the center. Camp and colleagues' findings are at odds with those noted in Hall and Cheston's study (2002), which suggest a lack of personal identification with peers among mental health service users. Our findings are closer to those of Camp and associates, by documenting a sense of togetherness in treatment settings for all seven focus groups, as well as favorable perceptions of these settings in providing meaningful activities and enabling members to manage and cope with their health concerns. As mentioned earlier, Hall and Cheston (2002) recognized that identities such as gender, ethnicity, and sexual orientation were meaningful to their study participants. Given that several of the focus groups in the present study were organized along the lines of ethnicity and sexual orientation/gender identity, the sense of belonging captured in treatment communities might in part be attributable to these common identities.

Conclusions

The findings of this study illustrate that identities other than those associated with mental illness and the role of a mental health consumer are critical to the understanding of the psychological sense of community among people with psychiatric disabilities. Although members of the population under study are often bereft of socially valued positions and roles, it does not mean that they are necessarily insulated within the mental health community. Recognizing the multiple markers of personal identity, including ethnicity, sexual orientation and gender identity, and religious faith is integral to the goal of community integration.

Mental health professionals and paraprofessionals need to empower service users to expand their "personal communities" beyond that of mental health client, using their diverse identities, and to design intervention strategies for addressing the stigma emanating from identities that are discriminated against by the wider society. Researchers in the field of psychiatric disabilities need to further explore the intersectionality of multiple identities in relation to community building among members of this

population. A promising avenue of inquiry pertains to the understanding of role-choice behavior in addressing the question of why, where choice is possible based on multiple statuses, one role-related behavior choice is made rather than another (Stryker, 2002). Such an investigation could illuminate the psychological process involved in determining how the salience of a certain identity emerges in affecting the exercise of behaviors concordant with that identity.

Authors' Note

Portions of this article were presented at the State of Knowledge National Conference, September 19, 2006, in Philadelphia, Pennsylvania.

Acknowledgments

We express our gratitude to the 62 mental health consumers who participated in this study.

Declaration of Conflicting Interests

The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research and/or authorship of this article: Funding was provided by research grant H133B031109 from the National Institute on Disabilities and Rehabilitation Research, U.S. Department of Education.

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