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An Exploratory Analysis of Unhealthy and Abusive Relationships for Adults with Serious Mental Illnesses Living in Supportive Housing

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ORIGINAL PAPER

An Exploratory Analysis of Unhealthy and Abusive Relationships for Adults with Serious Mental Illnesses Living in Supportive Housing

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Abstract Individuals living with serious mental illness are at high risk of chronic homelessness, victimization, and intimate partner violence. In recent years, supportive housing programs have emerged as one way to prevent homelessness and victimization for this population, while also expanding social interactions and social networks. In concert with a focal supportive housing program, this research conducted two focus groups with 18 individuals who have a serious mental illness diagnosis. The authors sought to answer the research question, "What are perceptions of healthy and unhealthy relationships among formerly homeless people with serious mental illness?" To this end, the eight-item questionnaire was created around dimensions of power and control, as well as relationship equality. Findings from an inductive thematic analysis reveal three broad families of themes (relationship ideals, lived experiences, and risk/resources in supportive housing), around which smaller themes and subthemes are organized. Implications for policy, practice, and future research are also discussed.

Keywords Serious mental illness · Chronic homelessness · Intimate partner violence · Supportive housing · Social networks · Healthy relationships · Relationship skills

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Literature Review

Serious Mental Illness and Chronic Homelessness

Serious mental illness (SMI) refers to a mental health diagnosis that substantially impedes an individual's everyday life (Center for Behavioral Health Statistics and Quality 2015). Roughly 4% of U.S. adults were assumed to have SMI in 2014 (National Institute of Mental Health 2016). In urban communities, the proportion of residents living with SMI is generally higher than national averages (Slade et al. 2014). One explanation that Padgett et al. (2012) found is that having experienced life-course adversity (e.g., intimate partner violence victimization) often correlates with SMI diagnosis.

Since the closure of myriad psychiatric hospitals and state institutions, individuals with SMI who are left with a paucity of physical resources are at greater risk for experiencing homelessness than ever before (Bengtsson-Tops et al. 2014). According to the United States Department of Housing and Urban Development (2011), 26.2% of homeless individuals using American shelters had SMI in 2010. Roughly 8.5% points more (34.7% total) homeless individuals using American shelters had been diagnosed with substance abuse problems, which may have been co-occurring with SMI (U.S. Department of Housing and Urban Development 2011). In fact, much of the existing SMI literature documents the co-occurrence of SMI and substance abuse (e.g. Collins et al. 2013; Oh and DeVylder 2014; Viron et al. 2014). In a systematic review of empirical literature, Roy et al. (2014) determined that adults with SMI who are homeless are more likely to be victimized than those who are not.

Supportive Housing and Social Relationships

In recent years, the Housing First movement has emphasized supportive housing as one approach to mediate the risk factors of having SMI and experiencing negative outcomes related to homelessness. The State of New York, Office of Mental Health (2015) defines supportive housing as "an initiative to facilitate an increase in long-term/permanent housing options for people with mental illness" (p. 5). This form of supportive housing allows individuals with SMI to become more independent in meeting personal needs, while maintaining on-site access to helping professionals (Haskell et al. 2016). Cultivating pro-social relationships is among the primary aims of supportive housing for psychiatric consumers of the Housing First movement (Temple University Collaborative 2011; Yanos et al. 2004; Wong and Solomon 2002).

Adults with SMI tend to report smaller social networks when compared to the general population (Casas et al. 2014; Kilbourne et al. 2007; Padgett et al. 2008; Pernice-Duca 2008). This may be due, in part, to the difficulties of establishing lasting social relationships in the context of the chronic homelessness that plagues this population (Padgett et al. 2008). In other words, it may be a struggle to maintain consistent relationships within the transient nature of a homeless living condition (Patterson et al. 2015).

However, entering supportive housing can offer homeless adults with SMI increased, positive social interaction that can transcend into building healthy, emotionally intimate relationships both inside and outside the residence (Haskell et al. 2016). Furthermore, adults with mental disorders who have entered supportive housing as a resource from homelessness have also reported increases in social support from both family (Henwood et al. 2014) and other members of their housing community (Patterson et al. 2105). Additionally, sometimes the small social networks of individuals with SMI are buttressed by the usage of technology (Naslund et al. 2016; Townsend et al. 2016).

More frequently, however, adults with SMI report feelings of isolation and loneliness (Perese and Wolf 2005; Wright and Kloos 2007) and difficulty in developing and maintaining social relationships (Padgett et al. 2008). Supportive housing is assumed capable of expanding a mental health consumer's relational network and impacting his or her overall perceptions of wellbeing (Brunt and Hansson 2002; Haskell et al. 2016; Patterson et al. 2015; Wright and Kloos 2007). For instance, participants in Haskell et al. (2016) study described how residents at care facilities benefited from activities, including regular socialization. Furthermore, formerly homeless research participants from other studies have noted growth in their social circle, including in their romantic relationships (Patterson et al. 2105).

However, with respect to intimate partnerships, individuals with SMI are assumed to be asexual (Bonfils et al. 2015). Yet, around a third of participants in Bonfils et al. (2015) study, although not in supportive housing, reported engaging in sexual activity in the 3 months prior to data collection. Many of those individuals felt that relationships and sexuality were important to them. Similarly, homeless participants in qualitative studies have expressed positive reactions in the development of romantic relationships upon entering supportive housing (Patterson et al. 2015). As such, supportive housing for this population may be a resource for building and maintaining positive romantic partnerships.

Unfortunately, stigma around having a mental health diagnosis can inhibit one from developing a healthy intimate relationship (Elkington et al. 2012). Consequently, SMI participants in Östman's (2014) mixed methods study perceived sexuality and successful intimate partnerships as unattainable. For example, they ranked "sex life" the lowest of all quality-of-life domains. In fact, SMI individuals who do engage in intimate relationships with undiagnosed partners are at risk for experiencing an inherent power differential with their undiagnosed partner (Elkington et al. 2012). For instance, participants in Padgett et al. (2008) study described engaging in turbulent and sometimes violent relationships, as they perceived few partner alternatives given their diagnoses and lack of material resources. As such, despite cultural stereotyping of individuals with SMI as being unstable and violent (Johnson and Miller 2016), they are, in fact, vulnerable to control and abuse victimization. Compared with general populations, individuals with SMI are at increased risk for experiencing intimate partner violence (Casas et al. 2014; Friedman et al. 2011; Khalifeh et al. 2014). For instance, two-thirds of the women in Friedman et al. (2011) study, all of whom were diagnosed with SMI, had experienced physical victimization (compared to a third of the United States female population) (Black et al. 2011; Breiding et al. 2014). Consistent with national rates of the overall population (Black et al. 2011; Breiding et al. 2014; Walters et al. 2013), women with SMI have a higher likelihood of being assaulted than men with SMI (Bonfils et al. 2015). Nevertheless, these individuals have sexual and intimate partner needs that must be fulfilled (Bonfils et al. 2015).

Theoretical Framework

A commonly utilized resource for understanding violent and controlling relationships is the Duluth Model of Power and Control (Pence and Paymar 1993). In addition to physical abuse, the model outlines other forms of power and control such as exerting power over a partner, using emotional abuse, isolation, as well as minimizing abuse (Pence

and Paymar 1993). Originally conceptualized as a tool for understanding the gendered component of intimate partner violence, it has been more recently criticized for failing to account for intersecting social positions such as socioeconomic status and disability, which may also influence an individual's vulnerability for violence (e.g., homelessness, SMI; c.f., Chavis and Hill 2008; Cramer and Plummer 2009).

In the interest of moving from unhealthy, violent, and controlling relationships, the domestic abuse intervention project (DAIP) developed the equality wheel (DAIP, n.d.). In contrast to identifying abusive behaviors, the equality wheel is characterized by healthy and supportive relationship behaviors: non-threatening behaviors, respect, trust and support, honesty and accountability, responsible parenting, shared responsibility, economic partnership, and negotiation and fairness (DAIP, n.d.). However, similarly to the power and control wheel, it is uncertain how these behaviors manifest in the relationships of individuals with SMI. Guided by an understanding of the aforementioned theoretical models, this research sought to answer the following question, and to achieve the explicated aim:

Research Question

What are perceptions of healthy and unhealthy relationships among formerly homeless people with serious mental illness?

Research Aim

To explore the ways supportive housing might help or hinder relationship-oriented risk.

Methods

Research Setting and Sample

Community strong (a pseudonym) is a robust social service agency in the third-largest city of a densely populated northeastern state. It provides social and educational services throughout the region. One service is the implementation of supportive housing for adults with SMI, who previously experienced chronic homelessness. The statutory definition of chronic homelessness refers to people who reside in places not meant for habitation (or places not meant for sustained habitation, such as emergency shelters), for at least 1 year, or on four separate occasions in the last 3 years (Register 2015). Per housing eligibility criteria, all adults in this sample had been chronically homeless prior to becoming a community strong resident. Additionally, all adults in this sample had been diagnosed with SMI. The statutory definition for SMI refers to adults that meet specific diagnostic criteria, which results in functional impairments that limit major life activities (Register 1993). All adults in this sample had been diagnosed with SMI.

After IRB approval was obtained, a formative, qualitative study was employed to explore perceptions of healthy and unhealthy relationships among formerly homeless individuals living with SMI. All qualified participants (English-proficient residents, who were at least 18 years-old) were invited to join the study. Participants were invited via a recruitment flyer that was distributed to them through their housing supervisor. This is evidence of convenience sampling, which recruits from known or intact groups (Farrokhi and Mahmoudi-Hamidabad 2012).

In total, 18 formerly homeless individuals with SMI (of 23 eligible individuals) elected to participate. Participants mostly identified as male ($n=12$). Of those who reported age ($n=17$), participants ranged from 25 to 65 years old (mean 49.2; median 51.0; mode 48.0). Their self-identified race/ethnicity included Black/African American ($n=8$), White/Caucasian ($n=5$), Hispanic/Latino ($n=4$), and multi-racial ($n=1$). Investigators did not probe for individual-level data about mental health diagnoses.

Measure and Procedure

The eight item interview guide was created by a qualitative researcher (also the PI), in concert with a relationship expert. It called on participants to reflect upon their friendships, intimate partnerships, and perceptions of healthy/unhealthy relationships. A full questionnaire appears in "Appendix" section.

The first-author facilitated two focus groups, each occurring at a single point in time (cross-sectional research). Utilizing a focus group technique facilitated the extraction of rich content, while also observing potentially rich interactions (Reid et al. 2014). The first focus group was comprised of 11 participants; the second focus group was comprised of 7 participants. Per Kruger and Casey (2000), each focus group was experientially homogenous. All participants were formerly homeless individuals with SMI, living in the same residential community. Per IRB approval, a graduate assistant took electronic notes on a laptop computer in real-time (no video or audio recording was allowed). To this end, the authors concede that the nuances of some participant responses were likely lost in the note taking process. Both focus groups took approximately 90 min to complete, and all participants received $20 for their time.

Thematic Analysis

Because the first-author was involved in every stage of data collection, it was imperative to recruit a second-author to help facilitate an object qualitative analysis. To this end, an inductive thematic analysis (Braun and Clarke 2006) was conducted by the authors. Each author reviewed the data separately, in order to ensure they did not influence each other's interpretation. By doing so, they were able to conduct a more valid analysis (Berg 1998). The first stage of thematic analysis is open coding, whereby the authors separately read through and became familiar with the data and were sensitized to patterns in participant discussion. Further, authors referred to field notes taken during the groups in order to assess nonverbal reactions (e.g., dissent, agreement; Braun and Clark 2006). Next, the authors engaged in focused coding, in which they identified broad codes, or families (e.g., healthy, unhealthy relationships). From these broad codes, the authors were able to specifically investigate how residents conceptualized healthy and unhealthy relationships, as well as the resources available to participants in the interest of building these relationships. After meeting to establish consensus, authors teased out these codes to form themes and subthemes regarding how these conceptualizations led to manifestations of participants' relationship ideals, lived experiences, and risk/resilience in supportive housing (Braun and Clarke 2006).

Through the entire analysis, authors adhered to Lincoln and Guba's (1985) recommendations for ensuring trustworthiness: credibility, transferability, dependability, and confirmability. To maintain credibility, authors wrote memos of initial reactions to data, as well as their thoughts over the course of analysis for reference at each stage, as well as during consensus (Creswell and Miller 2000). Although transferability could not be assured in applications to other settings, authors outlined thorough methods in order for their efforts to be replicated (Creswell and Miller 2000). Dependability was established through a comprehensive audit trail by authors and confirmability was established through triangulation between authors' interpretations as well as current literature (Creswell and Miller 2000).

Findings

Findings from the thematic analysis uncovered three overarching families of themes: relationship ideals, lived experiences, and risk/resilience in supportive housing. Table 1 summarizes these findings.

Relationship ideals refers to how participants perceive relationships should be. It is comprised of three themes: *mutual respect, trust*, and *good communication. Lived experiences* refer to the healthy and unhealthy relationships that participants have been privy to. It is also comprised of three themes: *relationship failure, surviving abuse*, and the *importance/difficulty of termination*. Finally, *Risk/resources in supportive housing* is comprised of two themes: *forced intimacy* (a risk) and *internal resources* (a strength). *Internal resources* includes two subthemes: *access to a counselor* and *access to legal resources*. Themes and subthemes are organized according to the three broad families previously mentioned (relationship ideals, lived experiences, and risk/resources in supportive housing).

Table 1 Summary of findings

Family	Themes and subthemes
Relationship ideals	Mutual respect
	Trust
	Good communication
Lived experiences	Relationship failure
	Surviving abuse
	Importance/difficulty of termination
Risk/resources in supportive housing	Forced intimacy
	Internal resources
	Access to a counselor
	Access to legal resources

Relationship Ideals

Participants described what they perceived a healthy relationship to be. Their collective ideals included a desire for fairness and shared responsibility vis-à-vis *mutual respect*. One participant indicated that a relationship "has to be fifty–fifty," while another participant contrasted that, "unhealthy relationships are take, take, take." As a third participant said, "[A] healthy relationship is when there is mutual respect, express[ing] feelings, and set[ting] boundaries. Take me as I am or don't." F or instance, a participant advised others to:

> Put themselves [and their needs] first [and] to make sure they fulfilled their goals and dreams. When we're young we may put others first and not us. Set boundaries. If you have some deep down secrets, you're entitled to your secrets.

A second prevalent theme in participant attributions of healthy relationships was *trust*. One resident felt that, "love and trust make a healthy relationship." This ideal was affirmed by multiple participants, who nodded in agreement upon hearing their neighbor's sentiment. The theme of trust was addressed in both focus groups. A second participant noted that, "a healthy dating relationship is communication and trust; an unhealthy relationship would be the opposite." A third participant described how "trust and

honesty and care make a healthy relationship." Elaborating on these ideas, another participant asserted that relationships are "a two-way road. I have to be trustworthy [and] I have to trust."

Good communication also emerged as a salient theme from the residents' discussion of healthy characteristics. As one participant offered, "a healthy relationship is someone you can count on. You can call that person and be straightforward." Another participant proposed that, in order to have a healthy relationship, "you have to be open and honest with each other. You just gotta do for each other all the time, help each other out all the time. Just to be open with each other."

Lived Experiences

Despite participants' almost unanimous descriptions of healthy relationships ($N=18$), none offered current experiences of being involved in a healthy relationship. One participant desired a relationship with, "a lot of respect, a lot of love, a lot of trust." She then disclosed that, "At this very moment, I'm not involved with anyone, but I hope to be." Although residents were able to identify attributes of healthy relationships, many described struggling to meet these ideals in their lived experiences. Most participants discussed *relationship failures*. In both focus groups, almost every participant had a story they wanted to share about a prior relationship. One participant offered that navigating relationships "is my worst subject." In order to better navigate these relationships, another felt the need to:

> Interact more with social skills…treat the other person how you like to be treated. I watch too much stuff on TV [and] that's not the way to treat people. Just improve on social skills. Just because one person does something doesn't make it right.

Another participant hoped others would not have to "go through the experiences that I have gone through." A different participant felt people should know, "there's a difference between sex and love, [because] it took me many years to figure that one out." In several instances across focus groups, participants attributed relationship failure to their SMI diagnosis. Some of these relationships were not only unhealthy, but also abusive.

In addition to relationship failure, *surviving abuse* emerged as a shared experience among participants. For instance, one said that "I was in an abusive relationship" and another described being "in a very abusive relationship for 5 years." In one focus group, two women found solace in sharing a similar story. In both focus groups, men also indicated having been in abusive relationships. "Words hurt more than bruises," said one male participant, referring to his lived experience. Interestingly, no participant discussed ways in which she or he may have perpetuated abuse.

All participants—through their words or through the nodding of their heads—affirmed the *importance/difficulty of terminating* an abusive or unhealthy relationship. Most agreed with cautions like "very seldom does a bad relationship get better." Another participant added, "[If] nothing is right here or there, [then] you're best off just separating. No point in adding fuel to the fire." With respect to the difficulty of terminating relationships, one participant said, "Sometimes leaving is hard. If you have feelings for someone, it's easier said than done." Another added, "it's easy to get used to the drama; used to the dysfunction, instead of leaving it alone." This sentiment was echoed by a third participant, when he said that "People go back [to unhealthy or abusive relationships] because it's familiar." Yet relationships did not always drag on or end in tumult. Contrary to his focus group peers, one speaker indicated that it was possible for relationships to terminate amicably. "We got separated," he said, recalling his own experience, "And it turned out fine. She's on her way, and I'm on my way." Regardless of the path taken to end the relationship, another resident advised others to "stay away from [your] ex, because it's going to mess up your emotions."

Risk/Resources in Supportive Housing

Although residents described the process of leaving abusive/unhealthy relationships as emotionally challenging, some descriptions of leaving unhealthy relationship were compounded by the *forced intimacy* of supportive housing. For a minority of participants in both focus groups, individuals had terminated relationships with fellow supportive housing residents. These individuals were then forced to maintain amicable relationships with ex-partners, who may have been physically or emotionally abusive. In the most extreme scenario, one participant described:

> I went into hiding for four days and then I went to a shelter… I finally got the courage and resources. The courage along with the resources gave me the info to call the shelter. At the time, they didn't have a bed available [but] I couldn't stay here [in supportive housing] because [my ex] was here.

Although this resident was eventually successful in ending her relationship, her termination process was complicated by having to navigate exo-level resources (i.e., shelters), as well as the micro-level system of the supportive housing.

As other participants noted, however, the *internal resources* available to consumers of supportive housing could empower some to end unhealthy relationships. The resources most commonly cited by participants in

this study was *access to a counselor* (a subtheme). Several participants mentioned the utilization of counseling services through community strong (e.g., "I tried therapy and that led to the end of the relationship") to help participants terminate relationships. Regretfully, individual-level data regarding the utilization of counseling services was not collected. An additional benefit of supportive housing was *access to legal resources*. While supportive housing programs are unlikely to provide an in-house lawyer, the focal program did expose at least one participant to proper legal channels that enabled her to file a restraining order against an abusive former partner. Access to legal resources is illustrative of a second subtheme related to the internal resources of supportive housing.

Discussion

Summary

Although participants aspired to relationships characterized by respect, trust, and open communication, participants also expressed difficulty in achieving these desired ideals. Many participants disclosed a history of unhealthy relationships and abuse. As a result, participants in this study provided recommendations on how to navigate and terminate unhealthy relationships, particularly using the resources provided to them by their residence, drawn from their own experiences.

Participant discussions of relationship ideals are consistent with literature characterizing healthy relationships, such as the equality wheel (n.d.). In fact, the themes that emerged from focus group discussion were in alignment with the DAIP's (n.d.) equality wheel, which emphasizes respect, trust, and communication. However, participants outlined their personal difficulties in engaging in, and maintaining, healthy relationships. Many chronicled personal experiences of abuse, as well as more modest relationship lapses in communication and trust. Formally homeless individuals with SMI have, similarly, in other studies described struggles with creating and maintaining social and romantic connections (e.g., Patterson et al. 2015). These are difficulties that may be addressed and ameliorated through healthy relationship education; however, little to no targeted education exists for this population at present (McClure 2012).

Contrastingly, participants in this study discussed violent and controlling relationships, in line with those outlined in the power and control wheel (Pence and Paymar 1993). Practitioners working with survivors of abuse (e.g., supportive housing supervisors, social workers, domestic violence advocates, mental health counselors, etc.) often aid consumers to leave these relationships, usually through safety planning (Murray et al. 2015). In some scenarios, participants sought the resources of their supportive housing infrastructure (e.g., utilizing police, seeking legal remedies, and participating in counseling) to facilitate the termination of their abusive or unhealthy relationship. Access to such supports is especially critical for adults with SMI who are involved in unhealthy or abusive relationships. Findings from other studies indicate there may be a dearth of social support for this population in leaving these relationships, making this already difficult task more strenuous (Casas et al. 2014). Herein lies a major strength of living in a supportive environment.

Indeed, participants discussed consulting with a counselor on ending a relationship as well as being referred to legal advice. Nevertheless, despite the stability of housing resources, the greater potential for intimate relationships, and the availability of counseling services, participants in this study did not report a positive effect on intimate relationships. As Cramer and Plummer (2009) note, many adults with mental health diagnoses struggle to access supports helpful and appropriate for them. It is possible that some participants in this sample are not discussing relationship issues with their counselor; it is also possible that participants are withholding identifying information that could be damaging to an intimate partner, who may also be a supportive housing neighbor. Consequently, it remains critical to consider the unique, yet understudied, experience of navigating relationships within the context of supportive housing for adults with SMI.

Implications

Adults with SMI, particularly those who live in supportive housing, have been widely overlooked in relationship research. As a result, little is in place in terms policy, practice, and research to foster healthy relationships and protect against the negative effects of unhealthy and abusive ones. As such, although the present study is exploratory, it lays the groundwork to fill this void.

Implication for Policy

First and foremost, research has indicated supportive housing as a resource in facilitating adults with SMI's positive social relationships as well as a resource to ending unhealthy ones. Yet, in the context of this study, knowledge of supportive housing resources did not necessarily yield a positive effect on participant intimate relationships. Suffice it to say, accessing these resources may be difficult (e.g., long waitlists, financial constraints; Haskell et al. 2016) for consumers of supportive housing. As such, healthcare for these populations through increased funding for more housing or adequate insurance

coverage should be addressed. Research has also indicated adults with SMI receive little to no care specifically related to building healthy relationships. As participants in our study indicated they struggled to maintain healthy relationships. This is unfortunate. Future funding in the realm of mental health services should take into account the costs to implement healthy relationship education as well as counseling that aids in fostering relationship and communication skills. Finally, as some participants discussed how they were involved in violent relationships with other supportive housing residents, all supportive housing programs should have a formal policy in place to address the safety of residents, should intimate partner violence occur.

Implication for Practice

Despite reports that adults with SMI struggle in maintaining positive, healthy, and fulfilling relationships (Östman 2014), little work has been done in terms of relationship education for this population. In order to remedy this, we urge practitioners to recognize and validate the relationship and sexual experiences of their clients. Such acknowledgement will serve to change common perceptions of adults with SMIs as being asexual. Similarly, extant research (Casas et al. 2014; Friedman et al. 2011; Khalifeh et al. 2014), as well as present findings, has supported the notion that this population is vulnerable to unhealthy and abusive relationships. Further practitioners who work directly with these individuals (i.e., housing staff, social workers) are wise to screen for violence and refer supportive housing consumers to other services designed for intimate partner violence intervention (Haskell et al. 2016).

Additionally, our results indicated adults with SMIs in supportive housing are in a place to receive healthy relationship education. For instance, participants explained that the counseling they received was helpful in ending unhealthy, even abusive, relationships. As such, counselors are in a unique position to work one-on-one with these individuals to promote skills that foster healthy relationships. Some practitioners may collaborate with family life educators (FLE) to implement support groups and programs specifically designed to prevent violence and promote relationship skills within this population. For example, participants indicated they struggled with communication skills; as such, programs may provide interactive relationship education that teaches these skills and allows participants to practice them in a safe, supportive environment. Additionally, as participants in this study described struggling to end unhealthy relationships, these relationship programs should work to teach skills in effectively ending these partnerships.

Implication for Future Research

Primarily, the present exploratory study seeks to highlight the nature of relationships among adults with SMI in supportive housing. However, given the vulnerable nature of the population, we were unable to record the focus groups. As such, future research should expound upon participants' perceptions and experiences by conducting further qualitative data collection (perhaps with an in-depth interviewing approach) from researchers and practitioners with research training who have long-term engagement in the field and, as such, are able to foster increased report and trust (Krueger and Casey 2000). Such techniques will allow for more in-depth investigation. Additionally, participants in our study were at the intersection of having a SMI diagnosis, a history of homelessness, and many were racial/ethnic minority individuals. Although it was beyond the scope of the present study, future research should examine how these vulnerabilities interact in this population's unhealthy and violent relationship experiences (Cramer and Plummer 2009). Lastly, in conjunction with recommendations for both practice and policy, researchers should collaborate with practitioners to develop data-driven and empirically tested relationship education curricula designed specifically for adults with SMI.

Limitations

There are several limitations to this study. First, participants were recruited into the sample from an intact, existing group. This form of convenience sampling means that consumers of other supportive housing agencies were not included. Consequently, findings cannot be generalized to other residential communities. Additionally, participants may have been enticed to participate because of the $20 remuneration, as opposed to a general desire to share their knowledge and insight. In spite of this, participants in both focus groups ($N=18$) were refreshingly blunt in their responses to focus group questions. Everyone contributed to the dialog in some way, and no single participant dominated either focus group.

A second limitation, however, pertains to the "groupthink" that seems to have emerged in both focus groups. Future research can avoid groupthink by utilizing an in-depth interviewing approach. While all participants in this study shared their perspective, few shared insights that were different from the group. Often, initial responses were echoed by a chorus of "I agree," with other participants eager to share anecdotal evidence for the initial response (but not contributing any new perspective). This limitation may be attributed to the study's small sample size ($N=18$), which further limits the applicability of findings.

While the focus group approach was wonderfully efficient, the authors wish responses were more nuanced and varied. For instance, although both men and women have been documented as survivors of abuse, they often experience violence differently and have different outcomes (e.g., women are more likely to be hospitalized as a result of partner violence than men; Black et al. 2011). As such, future research should investigate gender differences among this population. However, the majority of research on abuse in the context of individuals with SMI has been among women, and the inclusion of male voices provides a unique perspective. The inclusion of these male voices ($n=12$), however, may also have prohibited what women were comfortable sharing about health and unhealthy relationships. Additionally, since the study utilized a convenience sample, participants were previously known to each other to varying degrees. This may also have prevented the sharing of more nuanced information.

A final limitation pertains to the real-time note taking process, which was undertaken by a graduate student during data collection. This note-taking process was an IRB stipulation (no audio or video recording of this population was allowed). In spite of these limitations, the authors believe that this study makes a formative contribution to our collective understanding of healthy and unhealthy relationships for this population.

Appendix

1. I'd like to begin by talking about your relationships away from Community Strong. Tell me about the friends you spend time with for fun.
2. What qualities do you look for in your friends?
3. What happens if a friend breaks your trust? How do you deal with that?
4. Now I'd like you to discuss your dating relationships. What makes a healthy dating relationship?
5. What makes an unhealthy dating relationship?
6. If you've been in a relationship that you consider unhealthy, what did you do to fix the relationship? In other words: How did things turn out?
7. If you could design a program to help young people improve their dating relationships, what lessons would you include in that program?
8. Is there anything else you would like to share about healthy and unhealthy relationships?

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