WORK RECOVERY IN SCHIZOPHRENIA

by

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ABSTRACT

The goal of this study was to advance the development of theory related to the process of work recovery for individuals diagnosed with schizophrenia. The methodology was the explanatory, multi-case study. Purposive, criterion based selection procedures were used to recruit two adults diagnosed with schizophrenia who were employed in the community based labour force and one who had been unemployed for several years. The primary mode of data collection was the qualitative interview, focusing on the individual's experience of work recovery. Interviews with significant others and document analysis supplemented data and enhanced methodological triangulation. Strauss' (1987) elements of qualitative data analysis guided the analysis process.

Work recovery was conceptualized as an evolutionary transaction between the individual and the environment. Actual participation in work activities provided the ongoing feedback necessary to realize the individual's potential. The work patterns reflected a non-linear career trajectory with subtle but progressive accomplishments in the work realm. Individual characteristics associated with work recovery included: a strong work ethic; a flexible attitude towards work; the view that work experiences represented growth and learning; the belief that work participation was expected and supported by significant people, and; freedom from financial disincentives of government

disability benefits. Social networks that developed real work opportunities for the individual were particularly instrumental in the recovery process.

Work participation in the presence of persistent psychiatric symptoms was the norm. Psychotic features interfered with meeting the demands of work. Medications were the primary means of managing these symptoms, but active coping strategies compensated for learning problems, neutralized unpleasant affective responses and promoted social problem solving. The early management of psychosis was vital to maintain involvement in community based work.

A critical task of recovery was the individual's integration of the disorder and the self to create a functional identity in the work realm. A potential threat to the personal meanings associated with work, integration appeared to be the source of considerable stress. There was evidence that negotiating work demands in the presence of psychiatric symptoms prior to formal diagnosis and treatment of schizophrenia prepared individuals for the struggles of working with schizophrenia.

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v

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

WORK RECOVERY IN SCHIZOPHRENIA

Introduction

The North American employment rates for people with mental disorders are abysmally low, with studies suggesting that only ten to twenty percent of this population are competitively employed (Baron, 1995; Anthony, Cohen & Danly, 1988; Anthony & Blanch, 1987; Farkas, Rogers, & Thurer, 1987). Psychiatric rehabilitation research has focused on understanding the factors that influence vocational outcomes, particularly in response to studies suggesting that there is at best only a moderate relationship between the symptoms of psychiatric disorder and employment (Anthony, Rogers, Cohen & Davies, 1995; Anthony & Jansen, 1984; Strauss & Carpenter, 1972). For example, research efforts have been directed at clarifying the manner in which cognitive and emotional impairments are manifested during work (Lysaker, Bell, & Bioty, 1995; Lysaker, Bell, Zito & Bioty, 1995), the macroeconomic and social-cultural factors influencing work outcomes (Warner & Polak, 1995; Warner, 1994; Noble, 1998) and the nature of discriminatory work practices that contribute to high unemployment rates (Fabian, Waterworth & Ripke, 1993).

Most research addressing the factors that influence vocational outcomes has centred on people with severe psychiatric disorders, without differentiation based on diagnosis. This appears to be related both to the massive unemployment that exists among this broadly defined population, and to the fact that historically research has not consistently found a relationship between specific symptom patterns and work performance (Anthony & Jansen, 1984). However, more recent, methodologically improved studies are raising questions about the validity of earlier findings and suggest that subjects with a diagnosis of schizophrenia have poorer vocational

outcomes than other psychiatric diagnostic groups (Anthony, Rogers, Cohen, Davies, 1995). In addition, there has been increased attention to the possibility that the specific nature of work ability and disability may vary across diagnostic groups, suggesting that diagnostic differentiation within work related research is important (Lysaker, Bell, Milstein, Bryson, Shestopol & Goulet, 1993). This thesis will focus on the work recovery of individuals diagnosed with schizophrenia.

Typically research has focused on understanding the factors that explain the high rates of unemployment for individuals with schizophrenia. A relatively unexplored approach to understanding the factors that contribute to vocational outcomes is to study the experiences of work of those individuals with schizophrenia who have been successful in securing and maintaining competitive employment. This approach is based on the assumption that understanding the subjective experiences of work and the factors that contribute to successful work function provides important insights into recovery of work function. Furthermore the approach assumes that these insights are not attainable within traditional conceptualizations that focus on unemployment and the barriers to work.

This approach is consistent with the current trends in rehabilitation towards understanding the processes that are inherent in recovery from schizophrenia (Deegan, 1988; Anthony, 1993; Strauss, Hafez, Lieberman & Harding, 1985; Lord, 1991). Indeed, the concept of recovery has gained popularity as the mission of psychiatric rehabilitation (Anthony, 1993) and there has been a concerted effort in the field to develop recovery related theory (see for example Young & Ensing, 1999).

With its attention to the growth and change of individuals, a recovery orientation is considered a more empowering perspective than psychiatric rehabilitation paradigms that have

focused on deficits to explain problems in daily living. Recovery related research has provided important insights into the transformations associated with increasing levels of social functioning and personal well being. To date, however, ideas about recovery have remained quite general and have not addressed the processes as they apply specifically to different life domains, such as work, or to specific diagnostic populations.

Study Questions

This study examines the processes that lead some people diagnosed with schizophrenia to "beat the odds" and recover work functioning. An explanatory, multi-case study design is used to test theoretical propositions about the processes of recovery from schizophrenia within the work realm. The goal of the thesis is to advance the development of a conceptual framework for work recovery in schizophrenia.

The central research questions to be addressed by this study include:

1.) What are the essential features of work recovery in persons diagnosed with schizophrenia?

2.) What psychosocial factors are enabling in the process of work recovery?

3.) What is the relationship of work recovery to schizophrenia?

Specifically this research study will examine whether specific theoretical propositions which develop an explanation for work recovery in schizophrenia, are confirmed by a systematic analysis of multiple case studies.

Organization of the Thesis

The thesis is organized according to five major sections. The first section, covered in chapter 1, provides background information related to the problem. Chapter 1 also develops theoretical propositions related to work recovery through a review of the literature. The

methodology for the study is the second major section and is addressed in Chapter 2. Chapters 3, 4 and 5 represent the third major section. These chapters present the description and analysis of the individual cases of this multi-case study. Chapter 6 provides a cross case analysis. The final section, Chapter 7, offers a discussion focusing on the findings of the study and the implications for future research.

Employment outcomes and psychiatric diagnosis

While earlier studies suggested that there was no significant relationship between vocational outcomes and diagnosis, more recently research has indicated that people diagnosed with schizophrenia have poorer vocational outcomes compared to people with other psychiatric diagnoses (Cook & Pickett, 1994-95; Fabian, 1992; Lehman, 1995; Beiser, Bean, Erickson, Zhang, Iaconon & Rector, 1994). A large sample, retrospective study by Aro, Aro & Keskimaki (1995), found that individuals with schizophrenia were five times more likely than those with major affective disorder to be unemployed. In addition, the study indicated that the subjects with schizophrenia demonstrated a rapid downward social drift, typically moving directly from employment to unemployment, whereas the downward drift for those with major affective disorder was less abrupt.

Studies exploring the relationship between schizophrenic disorders and work have suggested that specific features of schizophrenia are associated with poorer work outcomes compared to other psychiatric diagnoses. These features include psychotic symptoms (Coryell & Tsuang, 1982; Tsuang & Coryell, 1993), deficits in ego functioning (Ciardiello, Klein & Sobkowski, 1988), problems with social interactions (Lysaker, Bell, Milstein, Bryson, Shestopal, & Goulet, 1993) underlying cognitive impairments (Lysaker, Bell & Bioty, 1995), and negative, amotivational symptoms (Anthony, Rogers, Cohen, & Davies, 1995).

Work rehabilitation and schizophrenia: Theoretical perspectives

The practice of psychiatric vocational rehabilitation has been strongly influenced by a particular conceptual orientation, the Vulnerability-Stress-Coping-Competence Model (VSCC) (Anthony & Liberman, 1986; Liberman, Massel, Mosk, Wong, 1985). This model is similar to the Diathesis-Stress Model in its structure and assumptions about the nature of the relationship between mental disorder and social-environmental stress (Strauss, Harding, Silverman, Eichler & Lieberman, 1988; Strauss, Hafez, Lieberman, & Harding, 1985). However, the VSCC model develops theoretical possibilities for the role of rehabilitation interventions in promoting participation in meaningful social roles, such as work, whereas the Diathesis-Stress model represents an essentially biomedical perspective on the disorder.

The VSCC model suggests that the individual has an underlying vulnerability for schizophrenia. It assumes that this vulnerability is psychobiological in nature and that it may be associated with subtle but longstanding impairments. This vulnerability is converted into a disorder, with observable signs and symptoms, when the stresses and strains of daily life overwhelm the individual's coping abilities. Stress has been identified as a factor in several health disorders (for example, cardiovascular disease, cancer, diabetes, arthritis, pain disorders, depression). However, the processes which determine the relationship between stress and disorder are believed to be highly complex and variable (Newberry, Jaikens-Madden, Gerstenberger, 1991; Lovallo, 1997), and the mechanisms by which stress is translated into health decline are poorly understood (Farmer & Ferraro, 1997).

The VSCC model suggests that the deleterious interaction between life's stresses and individual vulnerability can be mediated by medical interventions, such as medications, or by rehabilitation interventions, such as skills teaching, environmental modifications and the

development of social supports. (Anthony & Liberman, 1986). Medications are assumed to reduce the psychobiological vulnerability to stress, while rehabilitation interventions exert their influence by making stressful situations more benign, for example by building personal competencies and eliminating non-essential demands.

From the perspective of the VSCC model, employment is conceptualized as a social role that places demands on workers. The individual with a mental disorder is compromised in the worker role both because impairments associated with the mental disorder disadvantage the individual in performing the tasks of work and because work demands which tax the individual's coping abilities may lead to an exacerbation of the mental disorder. Medications prevent or control the exacerbation of the symptoms of the mental disorder, increasing the likelihood that the individual will be able to manage the responsibilities of employment (Kane, 1988), although medications do not directly influence work performance (Anthony, Rogers, Cohen & Davies, 1995). The role of medications in promoting work recovery is complicated by their potential to cause serious side-effects which pose barriers to the individual's ability to work (Kane, 1988; Rutman, 1994a; Mintz, Mintz & Phipps, 1992). Vocational rehabilitation interventions, implemented along with medications, are directed at developing work related skills, developing resources to support the individual on the job, modifying the characteristics of the work environment to facilitate performance and the opportunity for transitional employment experiences (Anthony & Liberman, 1986; Cook & Pickett, 1994-5). The combination of medications with psychosocial interventions has been found to lead to better clinical outcomes than either intervention alone (Hogarty, 1993; Hogarty, 1984).

Limitations of the conceptual framework

The VSCC provides a compelling framework for understanding the relationship between schizophrenia and employment but it has also been viewed as having serious limitations. The model is based on the assumption that the demands and stresses of the social environment are seen as having the potential to activate vulnerability and subsequently exacerbate the symptoms and impairments associated with the mental disorder. This places both the psychiatric rehabilitation practitioner and the individual with the schizophrenia in a "catch 22" situation, since all social roles pose demands and challenges which are considered stressful and thus potentially unhealthy. There is the real danger that the deliterious aspects of stress will be over emphasized, that the personal benefits of meeting daily life challenges will be minimized and normal responses to the stressful events will be confused with the aggravation of symptoms. (Bebout & Harris, 1995; Strauss, Hafez, Lieberman & Harding, 1985).

Work can be viewed as the most demanding and the most unforgiving of social roles. Employment, by definition, involves contributing to the economic and social structure of society by the production of goods and services. The goal of all employment is to increase proficiency and productivity of workers. Competitive work is organized to increase this proficiency and consequently stress is an inherent characteristic of all formal employment (Pearlin, 1982; Pearlin, 1989; Holt, 1982). The individual with a mental disorder who is unable to meet the demands and responsibilities of employment is highly susceptible to unemployment. This can be compared to participation in other social roles, for example the roles of family member or friend. Evidence suggests that the quantity and quality of these roles is different for people with severe psychiatric disorders than those in the general population, but that the roles are not completely absent. For example, the social networks of people with schizophrenia tend to be smaller and dominated by

kin relationships with less interpersonal reciprocity (Gillies, Wasylenki, Lancee, James, Clark, Lewis, & Goering, 1993; Gottlieb & Coppard, 1987).

The issue of employment is further complicated by the possibility that although unemployment may reduce the individual's susceptibility to the impact of work stress, unemployment has its own stresses. While leaving a stressful work situation may relieve distressed mental health (Thoits, 1994) the stress of unemployment has long been associated with mental health problems (Jahoda, 1981; Holt, 1982). Similar to the general population of unemployed, people with mental disorders struggle with poverty, the lack of meaningful and valued social roles, the reduction in social contacts and the lack of routine and structure (Warner, 1994; Hayes & Halford, 1996).

Furthermore, vocational programs that facilitate the entry of individuals with schizophrenia into the workforce typically target jobs that are entry level, unskilled and low in responsibility, because these jobs are perceived as less demanding (Baron, 1995). However, jobs with low levels of complexity and responsibility may actually be stressful. Unskilled and entry level jobs frequently lack job security and potential for advancement, minimize control and participation of the worker, tend to be highly repetitive, provide minimum wages and few benefits, and may be more susceptible to employee exploitation. These are all features associated with an increase in perceived work stress (Sauter, Murphy, and Hurrell, 1992; Kemp, 1994).

The Vulnerability-Stress-Coping-Competence Model conceptualizes stress as detrimental to the mental health of individuals with a diagnosed mental disorder. It does not consider the possibility that the process of coping with stresses within the context of work may potentially contribute to a positive outcome, the improvement of the impairments and symptoms associated with mental disorders. In support of this view, Warner (1994) in his review of the

international incidence of schizophrenia notes that admissions to psychiatric hospitals for people with schizophrenia is highest during periods of high unemployment. and lowest during periods of labour market shortages. Bell. Lysaker & Milstein (1996) used an experimental design to demonstrate that individuals with schizophrenia involved in paid work activity exhibited an improvement in all symptom domains when compared with a control group that was uninvolved in paid work activity. The processes by which these clinical benefits occur are unclear. Strauss (1986) has suggested that involvement in meaningful activities may impact on impairments by reducing the psychobiological vulnerability for the disorder. Other investigators have suggested that remaining active in society. effectively using one's capacities in meaningful and integrated work roles. gaining a sense of control over the illness. and developing coping strategies within the context of the job. are all factors that may contribute to clinical improvement (Van Dongen. 1996; Kirsh. 1996; Bell, Lysaker. & Milstein, 1996).

There is ample evidence to support the claim that psychiatric rehabilitation programs do not make the outcome of competitive employment a priority. A U.S. study of psychiatric rehabilitation practitioners revealed that only 9% of those surveyed considered placement of clients in the workforce to be a primary job responsibility (Blankertz. Baron. Hughes & Rutman. 1994). It has been suggested that psychiatric rehabilitation practitioners. even those working in vocational programmes specifically mandated to improve employment outcomes, do not pursue competitive employment for individuals with mental disorders, (Baron. 1995; McCrory. 1988; Torrey. Becker & Drake. 1995) and that programmes have been guilty of "creaming" off only those individuals they view as most likely to succeed at employment (Rutman. 1994a). In their review of rehabilitation programs and outcomes, Bond and Boyer (1988) found that programs without an explicit vocational focus may actually inhibit individuals with mental disorders from

pursuing employment. Their findings suggest that vocational programs that focus on preparing individuals for the demands of employment prior to placement in competitive work settings do not appreciably improve employment outcomes. In contrast, vocational programs which direct their efforts to the rapid, direct placement into jobs while providing continuing support, demonstrate employment outcomes appreciably above the norm for persons with mental disorders (Blankertz, & Robinson, 1996; Russert & Frey, 1991, Lehman, 1995).

Although the assumptions underlying the VSCC model appear to have considerable validity, critics have suggested that they are overly restrictive (Corin & Lauzon, 1992; Estroff, 1995; Davidson & Strauss, 1995). Essentially the VSCC is a model of "disorder". The model implies that the goal of rehabilitation efforts are directed towards the avoidance of the impairments and symptoms of the disorder. Employment is understood as social environmental stress that has the ability to exacerbate the disorder. Within this model research and practice efforts are focused on understanding and ameliorating personal characteristics that are considered barriers to employment. Even environmental level changes (such as work accommodations) are understood as a response to specific performance deficits of the individual.

An Alternate Conceptualization of Work recovery

Dissatisfied with current conceptualizations of mental disorder, several authors have proposed the development of an alternate framework which emanates from the belief that the ultimate goal for the individual with schizophrenia is the achievement of health rather than avoiding disorder. They emphasize acknowledging that individuals have strengths and competencies which influence the ability to enter into and manage socially meaningful roles such as employment. For example, Davidson and Strauss (1995) have suggested a "life context" approach which uses the person's subjective experiences and life story as a framework for

understanding health, illness and the recovery process. Hatfield and Lefley (1993) have proposed an adaptation framework for understanding the recovery process in schizophrenia. They suggest that in their fundamental struggle to survive, people with schizophrenia will actively employ coping responses to deal with the impairments associated with disorder, the functional sequelae of the disorder and social reactions to the disorder.

A common element in these conceptualizations is the central position of the individual as an active agent in determining the meaning and the course of recovery. The assumptions underlying the VSCC model view the individual as a relatively passive recipient of both the deficits of the disorder and the processes of amelioration. However, there is empirical evidence to support the view that the individual with schizophrenia should be understood as an active participant in the recovery process. Both empirical studies and first person accounts of people with schizophrenia have demonstrated that individuals with the mental illness actively participate in self-control of symptoms, self-monitoring of stress levels, modification of activities to decrease the impact of stress, and the selection and implementation of treatment and rehabilitation interventions to manage stressful situations (Brier & Strauss, 1983; MacRae, 1991; Carr, 1998; Lette, 1989).

From these perspectives the understanding of work recovery in schizophrenia is incomplete when only the management of symptoms and the development of work skills and resources are considered. An alternate approach is necessary, one which can incorporate the assumptions that individuals with schizophrenia: 1) are oriented towards the achievement of meaningful social roles, such as work; 2) may experience improvements in mental health in response to negotiating the demands and challenges of work, and; 3) use active coping strategies to manage the stress associated with challenging work roles. Such an approach should remain

sensitive to the impact that schizophrenia has on work functioning, but also give credence to the role of psychological and social factors.

The development of a theoretical framework to explain the recovery of social functioning in schizophrenia is in the early stages. To date there has been a tendency to generalized interpretations that consider the processes of recovery as they apply to all people with disabilities (Lord, 1991; Lord & Hutchinson, 1993). Lord's (1991) study suggested that many of the issues facing individuals in the recovery process may be specific to the disability group. Young & Ensing's (1999) study provides a broad interpretation of the recovery process for persons with severe psychiatric disability. However, now classic research studies have indicated that the outcomes associated with social functioning may vary between domains. Work outcomes are considered to be semi-independent of other areas of function (Strauss & Carpenter, 1972;1974). This suggests the need to consider the potential variability of the recovery process across specific life domains.

Despite the lack of a coherent theory, several theoretical propositions to explain the phenomenon of recovery of social functioning in schizophrenia appear in the literature. These propositions suggest the psychological and social factors involved in recovery. These factors are currently not well understood. It is unclear if they are all necessary components of recovery , or if there are necessary preconditions for these factors to occur. While the propositions are loosely tied together, the interactions between these factors is not clear. These theoretical propositions have been abstracted from a broad range of psychiatric rehabilitation literature including empirical studies using both qualitative and quantitative methodologies, descriptive papers and first person accounts of the experience of living with schizophrenia. These theoretical

propositions are developed in the following pages and have been applied specifically to the realm of work:

1. **Work recovery is best understood from a life course perspective.**

Work recovery in schizophrenia is a complex phenomenon, with many factors influencing work status (Rutman, 1994a; Lehman, 1995). While traditional cross-sectional studies have isolated many of the variables that mediate the work status of an individual with schizophrenia, they do not capture the interrelationships among these variables, and their relative importance over time. Subsequently they fail to provide adequate explanations for recovery. Life course perspectives attempt to understand and explain how particular outcome variables come about. They allow for an exploration of individual factors influencing work function, interrelationships between these factors and their relative importance over time.

Pavalko, Elder, & Clipp (1993) have argued that, in general, the research related to work, stress and health has tended to focus on the influence of single jobs on an individual's health, while the implications of life course and career patterns have remained virtually unexplored. This is particularly surprising given that work participation is considered a developmental process, with identifiable stages requiring the individual to negotiate ever changing demands and expectations (Super, 1980). The duration and prevalence of unemployment experienced by people with schizophrenia makes it particularly difficult to view their lives from a work life or career perspective. However focusing on unemployment undermines our ability to conceptualize that, even when unemployed, the individual may maintain a relationship to the social role of work and that this relationship evolves and changes over time.

Critics have argued that in general, research practices which use a cross-sectional and outcome oriented approach have provided an incomplete and overly negative view of recovery

in schizophrenia. (Harding, Brooks, Ashikaga, Strauss & Breirer, 1987; Strauss, Hafez, Lieberman & Harding, 1985). While advances have been made in examining schizophrenia from a variety of biological, psychological and social perspective, Davidson and Strauss (1995) argue:

> What remains difficult to achieve is a unitary framework that appreciates the constant interweaving of all of these elements throughout the person's ongoing life, providing a context for the transformations of health, illness, and recovery (p.49).

Unlike the other theoretical propositions addressed here, this proposition does not focus on a particular factor that influences work recovery. Rather it centres on a methodological issue: the best perspective from which to view and understand work recovery.

2. Positive meanings attached to the worker role facilitate the individual's ability to negotiate the stresses associated with the worker role.

Differential vulnerability to role related stress may be mediated by the meaning of the role to the individual. How the meaning of social roles, such as work, mediates mental health outcomes is unclear. Lavalle and Campbell (1995) demonstrated that the stresses of daily life are filtered through the individual's perception of the situation as relevant to his or her self-identity and self-worth. While personally relevant situations increased psychological distress, this distress was mediated by self-regulatory processes that were stronger than those initiated in non relevant situations.

Beiser (1995) has suggested that personal meanings may have physiological substrate and thus provide the "conceptual bridge" between biological and psychosocial models of mental disorder. From this perspective positive meanings attached to the worker role may influence the individual's health status. Davidson and Strauss (1995) point out that within the context of a meaningful experience, such as work, managing a stressful situation represents more than a small increment in an individual's ability to manage pressure. Rather, it represents an ongoing shift in

the person's view of the world and of the self that may render the individual less susceptible to exacerbations of the disorder. For example, the individual diagnosed with schizophrenia who accepts critical feedback from a job supervisor and successfully alters performance on the job may be less likely to view the workplace as hostile, more likely to view himself as responsible, and perhaps more likely to accept psychotropic medications that facilitate controlled moods and clarity of thought.

Simon's (1997) study of the personal meanings attached to social roles indicated that positive meanings provide individuals with the sense of sustained direction and commitment necessary to negotiate the chronic strains associated with employment. This may be particularly salient in schizophrenia where lack of self-direction and energy are considered integral features of the disorder (see for example, Andreason, 1982; 1991). Studies of the role that work plays in the lives of people with serious mental illnesses have repeatedly demonstrated that work provides direction in day to day living, a sense of accomplishment and usefulness, an acceptable social identity, and a measure of financial well-being (Godschalx (1987) cited in Hatfield & Lefley, 1993; Lord, Schnarr & Hutchinson, 1987; Scheid & Anderson, 1995). These perceived benefits of employment may provide the drive necessary to maintain participation in the worker role and subsequently to experience the positive impact that work participation may have on mental health (see for example, Bell, Lysaker & Milstein, 1996)

3. **A central feature in work recovery is the individual's perception that it is possible to create a functional self-identity separate from the disorder.**

Studies of the subjective work experiences of individual's with major mental disorders have highlighted the critical role of self-identity in the recovery process (Kirsh, 1996; Bebout &Harris, 1995; Lysaker & Bell, 1995a; Davidson & Strauss, 1992). Davidson and Strauss (1995;

1992) have argued that basic to the process of recovery is the development of the individual's belief that a functional self, beyond the limitations of the mental disorder is possible. Recovery within this context does not refer to a "cure" for the disorder, but rather the belief that one can choose a direction and have a measure of control and influence in daily life in spite of the illness. This belief is considered to be a catalyst for the individual becoming an active participant on behalf of his/her own well being.

A disruption of the sense of self has been identified as a key feature of schizophrenia, although the exact nature of this disruption is a source of disagreement (Hatfield & Lefley, 1993). The disturbance of self has been conceptualized both as a core symptom of the disorder, occurring as a result of the disintegration of feelings, thinking and drive, and as a response to the hopelessness, loss of social roles and stigma surrounding schizophrenia (Estroff, 1989). The objective presentation of this disturbed sense of self includes passivity, inactivity, social withdrawal, and disturbances in self-direction (Lysaker & Bell, 1995a; Krupa & Thornton, 1986). Lacking a clear sense of self and direction, both the individual's subjective sense of self and objective behaviours become organized around the role of the psychiatric patient (Lally, 1989; Lord, 1991).

Lally's (1989) study of engulfment into the patient role suggests a developmental process whereby both the primary symptoms of psychosis (i.e. hallucinations), and responses to the illness (i.e. medications, psychiatric hospitalizations, income security) interact to influence the individual's definition of the self as a patient. Beiser (1995) has argued that biomedical and rehabilitation models of schizophrenia potentially thwart the development of personal control and responsibility by providing secular definitions of the disorder and encouraging faith in the healing powers of technology. Lord's (1991; Lord & Hutchinson, 1993) qualitative studies of the

personal empowerment process of individuals with disabilities suggest that resolving issues related to the patient role were particularly salient for people with psychiatric disabilities.

Disturbances in volition present a barrier to employment for the individual with schizophrenia. These disturbances can be formidable for psychiatric rehabilitation practitioners who are perhaps ill prepared to deal with the disturbances in volition that affect sustained direction and commitment to the worker role. Lysaker and Bell (1995a) propose that the disturbances in self-direction in schizophrenia witnessed in vocational rehabilitation settings arise from a disturbance of self identity which preclude the experience of meaning in activity and subsequently the ability for purposeful choice. Bebout and Harris (1995) concur that work inhibition in schizophrenia represents a primary disturbance in identity and suggest that "... perhaps the business of getting to work is less about finding something to do and more about recovering or discovering something to be" (p.401).

Several authors have suggested that a critical feature of recovery of social functioning is the individual's ability to simultaneously accept the limitations imposed by the disorder while refusing to accept that the disorder predicts the future (Deegan, 1996; 1988; Lally, 1989; Hatfield & Lefley, 1993; Lord & McKillop Farlow, 1990). Maintaining a self-directed orientation is believed to reduce the experiences of demoralization and distress associated with losing control of one's life, and to increase active coping and problem solving in the face of difficulties (Mirowsky & Ross, 1989).

4. Internal locus of control, self-esteem and commitment are psychological factors associated with work recovery.

The process whereby an individual manages the demands of stressful situations is typically referred to as coping. There is a growing recognition that there is much to be learned

from people who have survived and adapted to unusually difficult circumstances. For example in the health care literature studies have focused on the coping strategies used by homeless men (Murray, 1996), high functioning incest survivors (DiPalma, 1994), and those who are stigmatized by labels of mental illness (Link, Mirotznik & Cullen, 1991). Only a few recent studies, of an exploratory nature, were found to focus specifically on the coping process of individuals with mental disorders who are managing the demands of competitive employment (Alverson, Becker & Drake, 1995; Krupa, Lagarde, Carmichael, Hougham & Stewart, 1998; 1999). Understanding the personal coping resources involved in maintaining employment may assist in the development of potent interventions to facilitate work rehabilitation and integration.

Coping is a complex phenomenon conceptualized as having two distinct dimensions, coping resources and coping strategies (Thoits, 1995). Coping resources can be either personal or social characteristics upon which the individual draws to facilitate the management of stress. Coping resources are believed to reduce the experience of stress by reducing the individual's appraisal of threat, and increasing the individual's appraisal that stresses will not exceed the ability to adapt (Lazarus & Folkman, 1984; Thoits, 1995). Coping theories are based on the assumption that the way an individual appraises a situation may be as influential on mental health as the actual stresses inherent in the situation (Lovallo, 1999; Aldwyn & Revenson, 1987).

Several personal characteristics have been associated with the active participation in coping with demanding social roles such as employment. These characteristics are considered to be dispositional orientations to select and initiate effective coping strategies rather than as enduring personality traits which specify typical responses to stressful situations (Kemp, 1994; Stone, Greenberg, Kennedy, Moore & Newman, 1991). The characteristics include:

a.) an internal locus of control, or the belief that through one's own efforts, one has the ability to effectively alter the outcome of a stressful situation (Terry, 1994, Lazarus & Folkman, 1984);

b.) self-esteem, the individual's confidence in his or her ability to effectively manage demanding situations (Terry, 1994; Fleishman, 1984), and;

c.) challenge, the individual's view that situational demands are challenges and opportunities for growth rather than as a threat to well-being (Lazarus & Folkman, 1984).

These personal characteristics, believed to buffer the individual against the deleterious effects of stress, have been referred to collectively as "resilience" or "hardiness" (Kobasa, Maddi & Kahn, 1982; Florian, Mikulincer & Taubman, 1995). They are psychological resources that facilitate the sustained commitment to negotiating stressful situations because of the belief that they can be managed (Florian, et al., 1995) The characteristics mobilize a proactive stace vis a vis distressing events, to anticipate events and to develop the skills and resources necessary to manage problems (Mirowsky & Ross, 1989).

The ongoing stresses that are associated with employment are frequently referred to as chronic strains. These strains have consistently been shown to have a damaging effect on mental health (Thoits, 1995). Stress research has focusd on the relationship between stress and anxiety or stress and depression. Individuals diagnosed with psychotic disorders such as schizophrenia are typically purposely excluded from stress studies. Yet, Hatfield and Lefley (1993) argue that the individual's appraisal of stressful situations are critical in schizophrenia because it is the single variable "...that mediates for the afflicted person the meaning and evaluation of the symptomatic condition"(p.21).

Although resilience is likely negatively related to schizophrenia it should be considered as a distinct psychological mechanism (Davidson & Strauss, 1992; Brockhurst, 1996; Strauss,

Harding, Hafez & Lieberman, 1987). This personal characteristic is the psychological manifestation of the individual's belief in a functional sense of self, and subsequently may be very influential in determining the recovery of social roles such as work. Recovery related literature has highlighted the interrelationship between the evolving sense of self and the development of personal coping resources (Lord & McKillop Farlow, 1990, Lord & Hutchinson, 1993; Davidson & Strauss, 1992).

5. **The individual's perception that valued people believe in his/her potential is associated with work recovery.**

Social support has been the most widely studied coping resource (Thoits, 1995). It is believed to mediate the impact of stressful life demands, such as those associated with the worker role, by influencing the meaning attached to stresses, promoting effective coping responses and facilitating mastery (Pearlin, 1989; Thoits 1995; Harlow & Cantor, 1995). When individuals are particularly vulnerable to negative mental health outcomes in response to stressful situations, social support is believed to act as a "buffer" to reduce the likelihood of relapse (MacKain, Liberman, & Corrigan, 1994). The nature of the relationship between social supports and the recovery of individuals with schizophrenia is complex and poorly understood. For example, families have been viewed both as essential to the well being of the individual with schizophrenia and as the source of interpersonal conflicts resulting in the exacerbation of symptoms and the perpetuation of dependence and incompetence (Hatfield & Lefley, 1993).

Empirical studies and published personal accounts focusing on workers with schizophrenia have revealed that, similar to the general population, they depend on friends and family for informational, practical and emotional support to assist them in finding and maintaining work (Kirsh, 1996; Krupa, Lagarde, Carmichael, & Hougham, 1998; Lette, 1989).

It appears, however, that prior to active involvement in the working role, people with schizophrenia benefit from social supports of a different nature, supports that kindle the individual's belief in his or her own potential. This form of emotional support has been referred to in the psychiatric rehabilitation literature as the instillation of hope and has been considered a core principle guiding the development of services for those with severe mental disorders (see for example, Dincin, 1975; Rutman, 1994b; Beard, Propst & Malamud, 1982). Several individuals with schizophrenia who have recovered social function have highlighted the importance of valued others conveying this sense of hopefulness (Deegan, 1988; 1996; Lette, 1987).

Of course there are enormous obstacles to maintaining a sense of hopefulness. Families and friends are faced with mourning the loss of the goals and dreams they had associated with the individual diagnosed with schizophrenia (Hatfield & Lefley, 1993). They are likely to experience feelings of separation and alienation towards the individual related to disruptions in their shared experience of reality (Lally, 1989; Estroff, 1989). In addition to the emotional distress, families and friends themselves are faced with the enormous stress associated with the burdens of caregiving disrupted family relationships and the difficult behaviours that individuals with schizophrenia can exhibit (Hatfield & Lefley, 1993). Finally, their views of schizophrenia, and thus their view of their loved one are likely to be shaped by prevalent, and typically negative social attitudes. (Hatfield & Lefley, 1993; Lette, 1989). Even the attitudes of rehabilitation professionals, who practice within a framework espousing a belief in personal growth and autonomy, are likely to be influenced by the negative prognosis associated with schizophrenia that has pervaded the field for decades (Harding, Brooks, Ashikaga, Strauss & Breier, 1987).

Studies of personal empowerment and growth of people with disabilities by Lord and his colleagues (Lord & Hutchinson.1993; Lord & McKillop Farlow, 1990) have suggested that the individual's recognition that a significant person believes in his or her competence serves as catalyst for a changing sense of self and for taking risks in community roles. However it appeared that individuals were only able to make use of these supports once they began to entertain the possibility that other life options might be available to them. This is consistent with Davidson and Strauss' (1992) studies of the rediscovery of a functional sense of self in severe mental disorder. Their work indicated that the belief of a significant other facilitated the awakening of hope, but it became particularly important once the individual begins to believe in the possibility of a capable self. At this stage the individuals entered a period of serious self-appraisal when they were vulnerable to attitudes of others. Deegan (1988), a woman who became a clinical psychologist after years of recurrent hospitalizations and unemployment writes eloquently of the meaning of social support in kindling hopefulness:

> They did not overpower us with their optimistic plans for our futures but they remained hopeful despite the odds. Their love for us was like a constant invitation, calling us forth to be something more than all of this self-pity and despair. (p.14)

6. An integral feature of work recovery is the experience of employment as a positive influence on mental health and well-being.

The value of work in promoting mental health and well being of individuals is well known. In addition to allaying concerns related to finances, work can provide friendship and stimulation, strengthen the self-concept and sense of responsibility, and stimulate personal growth (Pavalko, Elder & Clipp, 1993). It is to be expected that individuals with schizophrenia who are working would also experience these benefits. It has been suggested that participation in

the work role may also play a central role in recovery from the disorder and its associated symptoms and impairments.

Several studies have explored the potential of work participation for overcoming the negative or volitional impairments associated with schizophrenia. Lysaker and Bell (1995b) present a compelling case study of a middle aged man who experienced marked improvement in a longstanding inability to initiate and maintain self-directed activity within the context of a personally meaningful work situation. Studies by Kirsh (1996) and Davidson & Strauss (1992) provide evidence that work can have a marked effect on the volitional aspects of the disorder, because of the ability of work to increase self-esteem, strengthen self-concept, demonstrate and develop capacities, provide opportunities for personal agency and control and instil a sense of hopefulness. Davidson & Strauss (1992; 1995) suggest that this improvement in volition occurs because these benefits of work participation facilitate the reconstruction of the functional sense of self.

Empirical studies have demonstrated that work participation can also lead to improvement of the positive symptoms of schizophrenia (Lysaker & Bell, 1995a; 1995b; Bell, Lysaker & Milstein, 1996; Van Dongen, 1996). Consumer accounts have indicated that work distracts from symptoms, counteracts the unpredictability of the inner world through structure and routines, and maintains a grounding in reality within the context of co-worker relationships (Van Dongen, 1996; Hatfield, 1989; Lette, 1987; 1989). The mechanisms by which work participation reduces symptoms is unclear but Davidson & Strauss (1992) have proposed that perhaps the increased sense of personal agency and control leads to attempts to self-control of symptoms and impairments.

Summary

The rehabilitation field has been greatly influenced by the Vulnerability-Stress-Coping-Competence Model (VSCC). The model conceptualizes the social adjustment problems of individuals with schizophrenia as the result of the interaction between psychobiological vulnerability and socioenvironmental stresses that lead to the exacerbation of symptoms. This review presents the model as an inadequate representation of the processes by which individuals with schizophrenia experience work function. Specifically, it argues that the model underestimates the complexity of work stress and that it cannot be assumed to be harmful to the individual's well being. Furthermore, the model fails to consider the possibility that individuals play a central role in actively coping with the demands of work, thereby mediating the work-illness interaction.

This literature review has focused on the relatively recent development of ideas related to recovery. Recovery is an alternate conceptualization to explain the processes that lead to improved social functioning for individuals with schizophrenia. To date, ideas about recovery theory have tended towards generalities and have not adequately addressed the extent to which the processes of recovery may vary across specific life domains or populations. The development of a coherent theory of recovery is currently in the very early stages.

The primary focus of this literature review was on the application of ideas about recovery to the work realm. Specifically six theoretical propositions related to work recovery were abstracted from the psychiatric rehabilitation literature. The following six theoretical propositions were developed: 1) Work recovery is best understood from a life course perspective; 2) Positive meanings attached to the worker role facilitate the individual's ability to negotiate the stresses associated with the worker role; 3) A central feature in work recovery is the

individual's perception that it is possible to create a functional self-identity separate from the disorder; 4) Internal locus of control, self-esteem and commitment are psychological factors associated with work recovery; 5) The individual's perception that valued people believe in his/her potential is associated with work recovery, and; 6) An integral feature of work recovery is the individual's appraisal of employment as essential to mental health and well being.

The focus of this research is the evaluation of these six theoretical propositions. The goal is to apply multiple case study methodology to further develop, empirically, work recovery theory.

CHAPTER 2

METHODOLOGY

Rationale for Case Study Methodology

The research methodology I employed for this study is the explanatory, multiple case study as described by Yin (1994). The study meets the three conditions that Yin considers essential in determining the suitability of the case study design. First my objective was to explain a phenomenon within its real life context. The case study method allows for the identification of specific variables, as well as their relationships over time. With its deliberate focus on the real life context, the case study allowed me to attend to multiple entangled variables, such as those raised in the theoretical propositions about work recovery. Second the research focuses on both historical and contemporary events, and the case study method allowed me to collect information about the phenomenon, both retrospective and current, and from a wide variety of resources. Finally the variables of interest in this study occur in a real life context and could not be manipulated (Yin, 1994).

The theoretical propositions which I have developed from the existing literature to explain work recovery in schizophrenia are relatively new. It is important to implement research strategies which increase understanding and develop confidence in these theoretical propositions. The case study method, if applied systematically and rigorously, is considered a good means to evaluate the credibility of theory and enrich understanding of poorly understood variables as they impact on specific outcomes (Glaser, & Strauss, 1970; Borg & Gall, 1989). The explanatory case study methodology allowed me to pose explanations for a series of events or for an outcome and to compare these with actual situations. It is a particularly useful methodology

when the explanations require observing the operational links between variables over time (Schuller, 1988; Yin, 1994; 1995). In this manner the findings of explanatory case studies, if they meet the criteria for case study trustworthiness, can expand upon and generalize to theoretical propositions (Strauss, 1987; Yin, 1994; Platt, 1988). Multiple case comparisons can provide unanticipated results which guide theoretical modifications or reformulations (Glaser & Strauss, 1970).

For the purposes of this study, I analyzed each case study in the multiple case study design separately for replications of the theoretical propositions of work recovery in schizophrenia, and for deviations from the propositions but for predictable reasons (Yin, 1994). Yin (1994) argues that if the predicted pattern of results is observed across the multiple case studies then this will lend considerable support to the theoretical propositions. Using the case study methodology I was able to attend to additional information related to work recovery, such as the nature of the relationships between these propositions, and the necessary conditions for the propositions to appear.

In addition to the logical functions the case study methodology serves rhetorical functions (Platt, 1988). It simplifies the complexity of abstract propositions related to work recovery by offering examples. I believe that the humanistic mode of presentation associated with the case study will facilitate the appeal and the accessibility of the analysis for both clinicians and individuals with schizophrenia and their families. Also, in a field where the outcomes for individuals diagnosed with schizophrenia are predominately conceptualized within a biomedical framework the case study approach will make visible psychosocial and subjective phenomenon which are typically under recognized and unappreciated.

The theoretical propositions suggest the need for qualitative research to explore human perspectives and processes. Qualitative methods are directed to the examination of the interactions between multiple realities and perspectives of complex phenomenon, such as the process of work recovery in schizophrenia (Sechrest, Stewart, Stickle, & Sidani, 1996; Stake, 1995). The methods of qualitative research allow for new theory development through the deep interaction with data to qualify and refine previous theory (Strauss, 1987). In this manner the recognition of new or situational interactions are facilitated even when the research is guided by a theoretical framework. This allows theoretical propositions, such as those presented in this thesis, to be "tested" against further, systematic observations (Sechrest, Stewart, Stickle, & Sidani, 1996).

Participants

Unit of Analysis

The primary unit of analysis for this study is the individual. This unit of analysis is consistent with the original research questions of the study which focus on the processes of work recovery in persons diagnosed with schizophrenia. The study uses a multiple case study design involving three individuals. Yin (1994) states that the multiple case study design is considered a robust design for providing evidence of replication of theoretical propositions. Each participant in the study is considered an individual case. I collected and analyzed the data separately for each case, followed by a cross case analysis.

While the overall goal of the study is to increase understanding of work recovery in schizophrenia, this study also attends to subunits of analysis, the theoretical propositions, within each individual case. For each theoretical proposition specific research questions and methods of

data collection were developed. The hypothetical relationship of each one of these propositions to work recovery has been described in Chapter 1.

Sampling Strategy

The sampling strategy for this study was purposive, and specifically I utilised criterion based selection to choose three case study participants. As suggested by LeCompte and Preissle (1993), I selected cases based on predetermined attributes that would serve to both reflect the study's purpose and guide me to information rich cases.

I selected two of the individual cases to represent individuals with schizophrenia who had been successful in the process of work recovery. They were chosen to allow for the opportunity to observe for literal replication and for further development of the theoretical propositions concerning work recovery. It should be noted that these individuals also represent extreme cases given the remarkably low rate of employment for individuals with schizophrenia. People with schizophrenia who are employed are not easily accessed for research both because of their low numbers and because they are not usually found within traditional rehabilitation services, a primary source for the recruitment of study participants.

The following are the specific criteria that guided my selection of these two cases:

1. These two individual cases are adults between the ages of 25 and 55. The age boundaries were developed to include individuals who were developmentally within the age range associated with adult employment. A younger age range is developmentally associated with schooling to prepare for work and the older individual with preparation for retirement.
2. The individuals have a clinical diagnosis of schizophrenia or schizoaffective disorder as defined by the Diagnostic and Statistical Manual for Mental Disorders, IV (American

Psychiatric Association, 1994). The DSM IV identifies the characteristic symptoms of schizophrenia as "... a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioural monitoring, affect fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention" (p.274). Individuals were selected if psychotic symptoms, the defining feature of schizophrenia and associated disorders, were the most prevalent characteristic of the disorder.

3. Both of the individuals live in the community. Hospitalized individuals were not included in the study, because they are more likely to be dealing with acute psychiatric symptomatology and unable to access work environments.

4. They are in paid part-time, or full-time work, integrated within the community based labour force. They had been working in the same job for at least three months to ensure a measure of work stability. The individuals were not involved in supported employment or other formal vocational service or program.

I selected one case study to represent an individual with a diagnosis of schizophrenia who has not been successful in achieving work recovery. This is in keeping with Yin's (1994) suggestion that the robustness of the multiple case study design is enhanced by including cases that provide theoretical replication, by producing contrasting results but for predictable reasons. This criterion guiding the selection of this case was identical to those described for the previous two individual cases, except this individual had not been employed in part or full-time work in the community based labour force for a period of at least two years.

Recruitment of case study participants

The first site for recruitment was the south eastern region of Ontario. I contacted either by telephone or in person, professionals employed by mental health services who were likely to be familiar with people diagnosed with schizophrenia. I described the study in an effort to enlist their assistance with recruiting participants. As a follow up I provided them with an information sheet describing the proposed study (Appendix A), assurance of ethics approval and phone numbers for key individuals to contact with concerns. These individuals included psychiatrists at general hospitals and provincial psychiatric hospitals, directors of community agencies and leaders of self-help organizations for people with severe mental disorders. I asked them to consider if they or their staff knew anyone who met the criteria for case selection and in addition was: 1) able to provide written consent to participate, and; 2) able to understand and speak English.

These recruitment procedures proved successful in locating two individuals to participate in the pilot study for the project but did not lead to the identification of additional individuals to participate in the study itself. Comments made by these service providers suggested that they were familiar with individuals with severe psychiatric disorders who were employed but that they could not identify individuals with a diagnosis of schizophrenia who were employed in the community based labour force. I then repeated the same recruitment procedures in a large urban centre in south central Ontario and the required number of case participants was identified.

While not wholly unexpected, I was startled at the level of difficulty I experienced in locating potential study participants. Certainly the problems associated with locating participants recalls the relationship between schizophrenia and employment rates. These recruitment problems provide additional evidence to support recent studies indicating that employment

outcomes among individuals with schizophrenia or with psychotic disorders are particularly poor compared to other psychiatric diagnoses (Massell, Liberman, Mintz, Rush, Giannini & Zarate, 1990; Jacobs, Wissusik, Collier, Stackman & Burkeman; 1992; Fabian, 1992; Anthony, Rogers, Cohen & Davies, 1995). An alternate explanation for these recruitment problems is the possibility that, given the social and functional implications of the schizophrenic diagnosis, clinicians are less likely to bestow the diagnosis when an individual presents with the high levels of functioning that are not typically associated with the disorder. The potential for this clinical bias been recognized in the literature and is believed to play a role in the ongoing pessimism about the course of the disorder (Harding, Zubin & Strauss, 1992).

Each individual was approached by the mental health service provider to inform them that Terry Krupa, a PhD student at the OISE/University of Toronto, and an occupational therapist was conducting a study. The staff person was provided with the information sheet to use as a script to describe the study (Appendix A). The staff asked the person if he/she would be willing to meet with the researcher. If the person was agreeable the staff provided me with the individual's phone number. I then contacted the individual by telephone to arrange a convenient time and location to meet. The meeting place was chosen to ensure quiet and privacy. All of the individuals preferred to meet at the site where they received services. At this initial meeting I explained the research project and obtained informed consent (Appendix B). I used thise same recruitment procedure for both participants in the actual case studies and in the pilot study.

During the initial meetings with the three actual case study participants I asked each of them to consider a pseudonym for the case study report, to protect their anonymity. They were also asked to identify other individuals in their formal and informal support network who they considered having information regarding their work recovery to contribute to the case study. I

asked them to contact these individuals to secure their agreement to participate. Each individual completed the Form 14. Mental Health Act. Consent to the Disclosure. Transmittal or Examination of a Clinical Record under Section 35 of the Act. to allow me access to medical records. Finally. they were asked to consider sharing with the me any documents such as resumes. school transcripts. or work performance reports to contribute to the study.

Description of Case Study Participants

The first case study participant was Winston. a 44 year old man employed as a part-time. relief. Community Worker with an agency that operates several residential group homes for individuals with developmental delays. Winston has been employed by this agency for the past 13 years. He is single and resides in a private house where he lives rent free in exchange for property management duties. He shares the house with a renter. a retired male. Winston is financially supported by the income from his job and a family inheritance. Winston was diagnosed with schizophrenia in his early twenties. He was hospitalized frequently over a six year period after the initial psychiatric diagnosis was made. He has had two brief psychiatric hospitalizations within the past two years. He receives monthly injections of Modicate. a neuroleptic medication.

Ann. the second case study participant, is a 46 year old female employed full-time as a clerical float in a medical records department in a large, general hospital. She has been employed within this department for the past twenty years. Ann shares an apartment with her mother, but she is financially responsible for her own living expenses. She was first diagnosed with schizophrenia at the age of 29, although she had several prior admissions to psychiatric hospitals beginning at the age of 18. Ann has received psychiatric treatment only as an out-patient for the past fifteen years. She receives the anti-psychotic medication Zyprexa.

George, the final participant is a 44 year old male, living on his own in a rent geared to income bachelor's apartment. He has been unemployed for the past seven years. George experienced his first psychiatric hospitalization at the age of 16 in his native West Indies. He has been hospitalized approximately fifteen times, with the last admission occurring two years ago. George is diagnosed with schizoaffective disorder. His psychiatric medications include Fluaxol by injection and oral doses of Duralith and Tegratol.

Data Collection

Pilot Study

I conducted pilot interviews with two individuals who met the criteria for work recovery. Both individuals participated in three interviews, with each interview lasting approximately two hours. I kept only written notes of the interviews.

The pilot study served two purposes. It allowed me the opportunity to hone my interview skills through practice and self-evaluation. I used Strauss, Schatzman, Bucher and Sabshin's (1981) categories to develop the initial protocol. The pilot provided me the opportunity to refine the interview questions. In particular the pilot study proved invaluable in assisting me with developing interview questions that represented the participants' world view.

Case Study Data Collection

The primary source of data collection was the individual with schizophrenia because of the study's focus on the individual's experience of work recovery. Data was also collected from significant others and primary source documents, specifically to facilitate the development of the chronology of the individual's work life, to contribute detailed pieces of historical information that are apt to be forgotten over the course of time and to enhance methodological triangulation (Hitchcok & Hughes 1995; Merriam, 1990).

The primary strategy for data collection was the qualitative interview. The interview is a particularly useful strategy for accessing the perspective and the experience of the individual. (Patton, 1990). The general interview guide approach was used for this study. This approach entailed the development of a list of questions or issues to be explored with each research participant. The guide ensured that the same subject areas were addressed with all of the study participants. Open ended questions allowed me to explore topic areas in greater depth.

All interviews with case study participants were conducted in person and were recorded and transcribed verbatim. Each interview lasted between ninety minutes and two hours. To maintain interest and momentum without overwhelming the participants, these interviews were held once or twice a week over the course of three or four weeks. I engaged in extensive note writing immediately following each interview to contribute additional information about the interviews and to record my own thoughts and questions.

The interviews with individuals identified from the case study participants' social network were conducted in person or over the telephone. Information from these interviews was hand written in the form of notes or direct quotes by me during and immediately following the interview.

Table 3.1 provides information about the process of data collection for each individual case study.

Table 3.1

Summary of Data Collection for each Case Study

Case Study	Interviews	Significant others	Documents
Winston	5	Past psychiatrist Current psychiatrist Childhood friend	Medical records Academic transcripts Newspaper article Job performance review
Ann	4	Psychiatrist Coworker	Medical records Academic transcripts Work related memo
George	4	Case manager	Medical Records

Definitions of Key Terms

The following are key terms that appear throughout the thesis. They are defined here to clarify their meaning for the purpose of this study.

Work

Work is defined as involvement in paid employment within the community based labour force. In those situations where other activities within the work realm apply (for example, parenthood, volunteer work) they will be specifically defined.

Work related activity

Work related activities refer to those pursuits in which an individual engages as groundwork for participation in work. For example, these activities include educational activities such as college or university level studies that have the primary purpose of preparation for work.

Purposeful activities

Purposeful activities are those pursuits in which an individual engages to provide purpose and structure to the day and as an expression of interest. For example, attending a night course to learn a hobby would be considered a purposeful activity.

Work Recovery

Work recovery refers to the achievement of stability in successful and satisfying participation in the community based labour force.

Strategies to Enhance Trustworthiness

Several strategies for increasing the trustworthiness of qualitative research have been applied to this study (Lincoln and Guba, 1985; Denzin and Lincoln, 1998; Merriam, 1998). I increased the potential for the study design to be applied in similar situations by the development of a detailed case study protocol and case study data base. These procedures increased the transparency of the research process. The detailed case study protocol specified the nature of the phenomenon and events to be studied. Along with these efforts at operationalizing constructs, interpretations and meanings were substantiated by the convergence of multiple sources of data. In addition, I analysed and reported each case study individually. I used the technique of thick description (Merriam, 1998, Creswell, 1998) to provide the reader with the detail necessary to make judgements about the trustworthiness of my interpretation of the data.

By collecting data from several sources and the restating research questions in several ways I attempted to ensure consistency of the data. In addition, I compiled a formal case study data base that can be subjected to secondary analysis. Finally, the initial draft copy of each case study report was reviewed for accuracy and agreement by the respective case study participants.

The application of qualitative research to case studies is particularly vulnerable to the threat of bias inherent when making inferences about the relationships between phenomenon. In qualitative case study inquiry the investigator is the primary instrument of data collection and interpretation and the trustworthiness of the research is subsequently threatened by the researcher's biases (Merriam, 1998; Lincoln & Guba, 1985). I minimized the risk of this researcher bias by using a respected and systematic data analysis strategy that demanded ongoing and intensive interaction with the raw data to compare and contrast emerging theory with previous theory (Strauss, 1987). In addition, I developed alternate explanations for the outcome of work recovery than those proposed by the theoretical propositions (Appendix C), to reduce the likelihood that the emerging theory would be developed within the context of my own biases. Field notes were also developed immediately following each interview and extensive memos were developed during the process of reviewing and coding the data. These included both my personal reactions to the data and specific directions to attend to critical information that appeared to be inconsistent with the theoretical propositions or compatible with rival explanations. Krefting (1991) extoled the virtue of this type of journal activity in enhancing the insight and sensitivity of the researcher and in increasing the auditability of the study.

A common challenge to the trustworthiness of case study research is the extent to which the findings can be generalized. The objective of this study was to achieve analytic generalization. That is, the study focuses on understanding the processes of work recovery for

people with schizophrenia. Dietz. Prus and Shaffir (1994) highlight the importance of research that develops our understanding of generic social processes by examining human group life in multiple settings and a variety of contexts. In this research study I attempted to contribute to the evolution of theory by the constant comparison between existing theoretical propositions and the case data.

To enhance analytic generalization I used a multiple case study design. This allowed me to increase the diversity of the phenomenon under study. Through the cross case analysis I was able to identify emerging patterns to make comparisons between cases. Finally, the use of thick description should allow readers to determine if these cases are reflective of their own knowledge and experience of work recovery, or the extent to which these findings can be generalized to any other individual with schizophrenia.

Case Study protocol and questions

Demographic data

The following descriptive information was collected for each of the individual case studies: age, gender, type of accommodation, financial situation, number and length of previous hospitalizations, and current medications. This information was collected from the individual during the course of the personal interviews and from the participants' treatment and rehabilitation records.

Case study questions

Table 3.2 presents the research questions addressed by the study, the sources of data and the specific strategies for data collection. This case study protocol served as a guide for the research. The proposed sources for data collection and strategies are also provided.

Table 3.2

Case study protocol: Questions, sources of data and strategies for data collection

Questions	Sources for data	Strategies for data collection
1.What is the individual's work career?	The individual Significant others Clinical records Records from Vocational services Job descriptions Resumes	Create a timeline that shows the individual's work career from adolescence to the present focusing on work related education, actual employment and work related goals. Describe the job title, the occupational status, the job requirements, the individual's satisfaction with the job and the reasons for leaving each job held. Were there turning points during the course of the work career? Why are these points noteworthy? Were there special accomplishments within the individual's work career? How as the individual occupied during periods of unemployment?
2.What is the individual's understanding of the relationship between schizophrenia and work?	The individual	How does the individual understand and explain the mental disorder? Was this always his/her view? How does the individual experience the relationship between schizophrenia and work? How do symptoms and impairments associated with the disorder influence work? How do treatments for the mental disorder influence work? Why does the individual think so many people with schizophrenia are unemployed?

Question	Sources for data	Strategies for data collection
		How does the individual cope/adapt to the specific challenges of managing work demands and the mental disorder?
3.What is the meaning of work for the individual?	The individual	What meaning does work have for the individual? How important is work to the individual? How does the individual describe themselves to others?
4. Do the following psychological factors influence work recovery: internal locus of control self-esteem and commitment.	The individual	How does the individual explain his/her own work recovery? How does the individual appraise work related demands? What is the individual's view of his/her abilities in relation to the demands of work? What impact does working have on other daily life activities? How does he/she manage this?
5.How does social support influence work recovery?	The individual Significant others	Develop a modified social network map of relationships influential to work. Who were the prominent people in the course of work recovery and why were they prominent? What are the attitudes and expectations of the family towards work?

Questions	Sources for data	Strategies for data collection
		What advice, related to returning to work, would the individual give to families with a member who has schizophrenia? What assistance did the individual receive from mental health professionals in relation to work?
6.What is the relationship between work and the individual's schizophrenia?	The individual Significant others	How has the individual's mental health been affected by working? What has been the status of the individual's mental health during periods of unemployment? How does working affect schizophrenia?

Data Analysis

The general analytic strategy for this study was based on the theoretical propositions developed previously. These propositions have guided the design of this research study, including the specific research questions developed within the case protocol and the boundaries for data collection. The theoretical propositions provide a natural organizational structure for the final case report, allowing for what Stake (1995) has referred to as the development of complex descriptions without the generation of "... far more plot than the story needs" (p. 124).

A dominant mode of analysis for explanatory case study research involves the search for patterns (Yin, 1994). Explanatory case study researchers using qualitative methodology are faced with the challenge of maintaining sensitivity to extant theory while engaging in the

interpretation of conceptually dense and complex data (Strauss, 1987). My analysis and interpretation for this multiple case study was guided by Strauss' (1987) main elements of qualitative data analysis. The analysis of the data was initiated and carried through the phase of data collection, including the pilot study. Throughout data collection I engaged in active memo writing to highlight critical information, to formulate new questions and as a preliminary process of coding information.

Upon completion of data collection, I approached the analysis and interpretation of each case study separately. However, given that the data collection for all three case studies was complete, my analysis of any single case was naturally influenced by data and knowledge gained from the other cases. In addition, given the focus of the study design on the development of theory, throughout the analytical process I engaged in a continuous transaction between the ideas arising from the raw data and those of the previously established theoretical propositions.

The audiotapes for each of the interviews were transcribed by an experienced dicta typist. Although the identities of the individuals on the tapes remained anonymous the typist completed confidentiality forms. I reviewed each of the transcripts for accuracy and to locate missing pieces of information. I then entered the transcripts into the NUD.IST computerized data management program (Richards & Richards, 1995). Both the transcripts and other raw data were then subject to a process of intensive open coding to produce comprehensive analytic categories. The raw data was then organized according to these analytic categories and I analysed each category again to develop an understanding of the meaning of the category and its relationship to other categories. In this process of axial coding, these categories were enhanced by developing linkages between categories and renamed to provide conceptual clarity to the phenomenon. The labelling of categories reflected both concepts from the social psychology field and those used by

the individuals during the course of data collection. The process of labelling was guided by my intention to reflect the individual participant's experience and the meaning of the phenomenon. Finally, I revisited these categories to further organize the coding into a system of core categories and their contingent categories.

Following the analysis of each case I proceeded to develop a written report that was composed of a description of the individual from a work perspective followed by an analysis of the case, organized by the framework of the theoretical proposition. I supported each case description and analysis with specific quotes from the interviews. These quotes are featured in italics.

The final step was the development of the cross case analysis. I revisited the analysis for each case study to compare core categories and contingent categories both to each other and to the extant theory. Through a process of active memoing and integrative diagrams, as described by Strauss (1987) I developed higher level categories that were more abstract and more generalizable to theory then those developed at the level of the individual case study. In addition, these integrative diagrams facilitated the process of establishing possible relationships between key phenomenon. I wrote the written report for the cross case analysis using the framework of the original theoretical propositions as the building block for the new emerging theory. Finally I developed a discussion of the emerging theory and highlighted the need for further study into these new generalizations.

Limitations of the Study

Since the case study method is used for advancement of theory rather than generalization to a larger population, three separate case studies is considered an acceptable number of cases. However replications of theory across multiple cases contributes to the confidence in the results.

Increasing the number of case studies would certainly be desirable, but is beyond the scope of this research project.

Perhaps the weakest aspect of this study is the fact that the theoretical propositions upon which the study is based are, at this time, poorly specified. While the theoretical propositions have been defined, they have not been causally linked, a situation which Yin (1995) suggests weakens the analytic process. The design has also been strengthened by the use of data analysis techniques which specifically address the problems inherent in developing new theory from existing theoretical propositions. In particular, I depended on Strauss' (1987) seminal work on qualitative analysis as a framework for a systematic approach to coding, analysis, interpretation and theory development.

Another limitation is my own investment in the predicted theoretical propositions and the subsequent danger of bias in data collection, analysis and interpretation. As a clinical occupational therapist, specializing in psychiatric rehabilitation, I am highly invested in challenging traditional biomedical conceptualizations that consider the nature and the course of the psychiatric illness to be the primary determining factor in the process and outcome of work recovery in individuals diagnosed with schizophrenia. Steps taken to reduce the likelihood of investigator bias include the apriori development of alternate explanations for work recovery and the development of a detailed case protocol that will allow for the expression and analysis of these alternate explanations.

Personal Reflections on the Research Process

I was generally pleased with the research process. I initially questioned the research design because of my difficulty locating suitable participants and the resultant logistical and practical issues inherent in carrying out "long distance" research. The data collection, once

arranged, provided detailed and rich information about the participants' work lives. In addition, each of the participants expressed a sense of pleasure and satisfaction with their involvement in the study. My impressions were that they appreciated being the focus of a case study both as a form of altruism and as an opportunity for self-reflection through the telling of their stories. I personally found the process of data collection, analysis and interpretation to be a highly rewarding experience. During the initial phases of analysis I questioned the integrity of deconstructing the experiences of these individuals into separate codes. My concerns were mostly put to rest when I entered and worked through the very difficult phase of integration of the analysis.

I found that the research process was negatively affected by the method of data collection from sources other than the case study participant. I decided not to audiotape my interviews with significant others primarily for logistical reasons. In fact, because of the distances involved I was forced to interview several of these people over the telephone further limiting the dynamics inherent in the interview process. While the information gathered from these interviews served as an important source of data for the purposes of triangulation, I found that the lack of verbatim discourse constrained my ability to integrate this data into the final report.

I also found it difficult to reconcile the need to maintain anonymity within a study design that selects individuals based on their uniqueness and explores their life situations in depth. In an attempt to deal with this issue I discussed the ethical concerns related to anonymity with each participant while obtaining informed consent and throughout the interview process. All of the participants indicated that they were comfortable with the case study format, citing the fact that they had previously been involved in public speaking engagements about their experiences in

living with schizophrenia. I changed any names or other identifiers within direct quotes to generic terms (for example, the proper name of a school was changed to "the college"). If the integrity of a direct quote was lost by making these changes I did not include it in the final report. Finally the participants were asked to review the written document of their respective case studies and to note any areas that they thought compromised their anonymity.

CHAPTER 3

CASE STUDY 1: WINSTON

Case Description

Undercover Agent

At forty-four years of age Winston is employed as a relief, residential counselor in a group home for seniors with developmental delays and psychiatric disorders. For thirteen years he has been giving residents their neuroleptic medications and facilitating their community integration. Every three weeks Winston visits mental health professionals at a psychiatric hospital to receive his own neuroleptic injection and support for his own community integration. The irony of the situation is not lost on Winston:

> *Winston (W): It's funny. I feel like I'm an undercover agent in some ways because I've got schizophrenia. I'm working with people that have schizophrenia and nobody knows it. I feel like I'm an agent or something.*

Winston believes that no one at work is aware that he has a diagnosis of chronic paranoid schizophrenia. In addition to his commitment to the job and his expertise as a community worker, there are several factors that assist him with maintaining his secret. Winston displays none of the associated movement or appearance side-effects frequently associated with neuroleptic medications. The psychotic symptoms of his illness are well controlled by these medications and rarely interfere with his work performance:

> *W: I'm lucky in some ways Terry. I respond well to medication. I'm lucky in that respect. Dr. X just hit upon Modicate and it worked. I don't hardly ever, ever, ever get psychotic or hear voices or have delusions. I'm just lucky I don't have...I respond really well to medication.*

He typically works alone, or with only one other employee, minimizing the social pressures for sharing personal information. His place of employment is a forty-five minute drive from his local community which reduces the likelihood that colleagues will view him within the context of

treatment or rehabilitation activities. The lack of a consistent schedule, a feature of relief work, provides Winston with the opportunity to conceal his infrequent periods of psychiatric hospitalization:

> *W: It was easy. You know I have a relief position. They called me for work three times. I found the messages on my answering machine and I never called them back and then when I got out of the hospital I called them back and told them I had been at the cottage. They know I have a cottage, they know I go there in the summertime.*

For Winston, schizophrenia has been both a "*curse*" and "*bonus*" on the job. On the positive side, Winston perceives that he has a special relationship with the residents of the group home because he can personally identify with their experiences with mental disorder:

> *W: So I can relate. Like Anna sleeps with her light on all night long and with her door open or else she gets claustrophobic. I can relate to things like that. Having doors closed, lights on.*

Winston believes that the residents experience his sensitivity and understanding as unique. This "insider's viewpoint" has posed a specific challenge for Winston. He found that he had to reconcile feelings of segregation from other staff that arose in response to his identification with the residents' vulnerability to the staffs' peremptory position:

> *W: I remember that's how it was when I started at work. I was very distrustful of other staff, thinking that they were authoritarian. I don't like being very authoritarian with my clients because like I know what it's like to be in an institution, to be under somebody else's authority. So I always saw the staff I worked with in the beginning as being authoritarian and me being a lot different because of my schizophrenic experience and me being institutionalized a few times.*

Winston is comfortable with his decision to not disclose his psychiatric disorder at work. He is not certain what would happen if his employers discovered that he has a diagnosis of schizophrenia. He is afraid that this information would predispose his employers to feel less confident in his abilities, and that this could translate into less work or being fired. Even though he has the requisite community worker diploma, stellar performance appraisals, and the longest

history of employment at his group home. he believes disclosure would place him in a vulnerable position:

> *W: Yes. oh. I've got the credibility. I've got the ... but whether the stigma of the mental illness can overpower the credibility that I've built up is a question I can't answer.*

The Foundation

By the time Winston was diagnosed with schizophrenia in his early twenties he had developed a substantial employment history and had already established an identity as a community worker. He believes that this work foundation positively influenced his motivation for work recovery:

> *W: I would be a lot more depressed if I didn't have a job. A lot more depressed. I'd feel... I don't want to use this word. but I would feel like a useless piece of garbage. Especially when I had worked in the past before I got ill and I had had some kind of foundation and I got ill and then I knew that I wouldn't be able to work again. like that would have a tremendous impact on me. It's not like I've never worked before.*

Winston began working regularly by the age of twelve in his family's convenience store. The nature of the business. with its long hours. pressed for his participation. This was compounded by the fact that his father was diagnosed with schizophrenia and family members were required to compensate for his episodic inability to function at work. An honour student in elementary and early secondary school. Winston excelled in the social sciences and aimed for a career in the human services:

> *W: Yeah. I wasn't going to be a scientist. I was going to be a social worker. I had no idea that community work existed. but I wanted to be a social worker or just somebody working with people in some capacity. working with people who had problems. some sort of problems.*

By grade eleven Winston found himself unable to maintain his efforts towards high academic performance with the strict demands for contributing to the family business. He describes this as the source of considerable family conflict. Unable to reconcile these competing

pressures Winston became increasingly estranged from family and from school. He responded by associating with the high school subculture of social rebellion:

> *W: I decided what's the point of school anyway? Why try so hard when it's not getting you anywhere. You just being there. with resistance. and your life is more important than marks. and all of this crap then. So I didn't take school so seriously anymore. my marks started to drop and I started growing my hair long and listening to rock bands and all of that kind of stuff.*

In grade twelve Winston voluntarily left the family home to live in a group home operated by a child service and to work regular part-time hours. He withdrew from school two weeks before the final exams for his final high school credits:

> *W: You know school was not an object of where my mind was working anymore. I was on to other things. I really wanted to get out of high school. I found it really irrelevant at that point.*

Through his caregivers at the group home Winston found full-time child care related work with troubled youth. Winston believes that his rebellious lifestyle was considered an asset on the job in that he served as "*role model*". His time as a child care worker was followed by a job as a community worker at a psychiatric day hospital, again arranged through previous work connections.

Winston believes that although this work foundation represents an atypical work path it provided him with invaluable life experience and success in his chosen career field:

> *W: Right. Like in some ways quitting school was the best thing I ever did because it gave me six years of work. I look at it that way.*
> *T: Yeah. It's an interesting thing that happened...*
> *W: Like had I gone to university and gotten ill in university I'd just be another schizophrenic with half a B.A. that never worked and never had any work experience or... but I had some work experience, I had child care and community work.*

Psychosis and Work Recovery

Winston experienced intense and lengthy episodes of depression during his final years of high school, until his first diagnosed episode of schizophrenia at the age of twenty-one. He describes this depression as extreme feelings of hopelessness and suicidal thoughts. He is uncertain about the relationship between this early depression and his subsequent diagnosis of schizophrenia. Winston worked throughout these periods of depression and credits employment with lessening their impact.

Winston's first medically diagnosed episodes of paranoid schizophrenia occurred within the context of legal charges for criminal offenses, social isolation, ongoing family conflict and the continued use of street drugs. The symptoms of the mental disorder included paranoia and hallucinations, and were so intense and distressing that they led to extreme suspiciousness, and social withdrawal to the point of homelessness:

> *W: Okay, well I was probably in the worst shape of my life at that time, that I'd ever been in. I had lice, they had to bathe me with Qualata, I remember I had a beard, long hair, I hadn't changed my clothing in five months. I probably smelled. They bathed me with Qualata to get rid of the lice. I came in right off the street. I'd been living on the street. I came into a ward. I was totally confused. I didn't know what was going on. I was mute. One reason I was mute was because I was paranoid because I thought the police had followed me into the ward and were trying to collect evidence on the trial, on the upcoming trial, so I wouldn't talk to anybody about anything. So for about two months I didn't say anything to anybody, which didn't help.*

His psychiatrist at the time confirms that Winston was "*more sick than almost anybody, catatonic, mute.*"

Convinced that his experiences were the result of a conspiracy involving his family and the police Winston remained resentful and resistant to treatment for five years. Although he initiated contact with the psychiatric hospital, he expected that his problems would be understood

within the context of the family dynamics. Instead he found that he was identified as the person with a problem and that the focus of their assistance was psychiatric medications. His psychiatric treatment history during this period included frequent lack of compliance with prescribed medications and eight admissions to a psychiatric hospital. Winston credits his eventual acceptance of psychiatric treatment with two events: 1) the realization that, despite terminating contact with his family, the legal system and the hospital, he had lost all of his valuable personal possessions and was living on the street 2) a trial of Modicate injections leading to successful control of his symptoms without side effects:

> *W: This was real...this was success and it was only because I was staying on medication. I had gotten rid of all of that denial and I'd been through the experience of living on skid row twice. ... I'd lost my car. I'd lost everything. I knew that if I ever went off medication again I would lose everything again as sure as the sun rises in the east.*

Work remained a constant force in Winston's life, even when his mental illness was at its worst:

> *W: Oh yeah. I was always looking for work... Yes I still thought I was well enough. I still had this idea in my mind that I could work. Like I remember walking up this street, going into the bars and asking them if I could wash their floors for them, mop their floors.*
> *T: And what was their response?*
> *W: Oh, it was negative. I mean they could see, you know look at me and say this guy is sick or a street person and yet I was still going to wash floors.*

During the period of what Winston refers to as his "*mental framework of denial*", he completed a one year academic preparation course for university studies. This educational program was directed to assisting individuals who were disadvantaged. His return to school represented a purposeful effort to use education to circumvent the socially marginalized identity of a mental patient. It provided him with the opportunity to recognize his desire for occupational achievement in spite of the schizophrenia:

W: First of all it was out of desperation. There was nothing else. There were no other avenues. I wanted to go to university. I wanted to get an education. Before this I had been applying for jobs too and kept on getting rejected because I just didn't have any academic qualifications. I didn't have a piece of paper. I didn't have a diploma or a certificate, okay? So I knew I would have to go to school to get a piece of paper. So there was that driving me... That's why I get down, why I get depressed because I don't feel I've been able to achieve as much as I would have liked to or could have had I not succumbed to schizophrenia.... And desperation that there's nothing else, this is the only avenue open to you. You've got to make the most of it. And I wanted to do something with myself. I just didn't want to stagnate. I just didn't want to be a mental patient. You know. I wanted something better for myself.

Furthermore Winston's educational efforts were consistent with the achievement values of his family. His acceptance of treatment for the mental disorder and his return to school elicited recognition and support from family members who themselves were no longer pressured by the demands of the family business or by financial concerns.

Winston found this educational program to be a good match for his own needs and goals. It allowed him to pursue meaningful studies with his own peer group. His psychiatrist was enthusiastic about his academic efforts, providing him with quiet rooms to study, day passes from the hospital to attend classes, flexible appointment schedules, and assistance with academic preparation:

W: Before I entered school my psychiatrist and I discussed this. He said you're going to have to learn how to concentrate all over again, because your concentration isn't very good, you've been ill. And that was true. All I could read was papers, I couldn't read books. I had to read a lot at school. So, before I entered school I started reading a lot of novels, paperback novels.

Winston experienced the staff of the academic program as caring and committed to his success. He was open in his disclosure of both his psychiatric disorder and his efforts to cope with the ongoing symptoms of the illness:

W: Yeah, I thought these people would understand. Yeah, these were educated people, these people would understand. I didn't tell them to get any favours. I just told them like there would be certain difficulties that I would have like with something and I would say

well listen. Okay. I remember being in a tutorial and having to leave the tutorial all of a sudden because I had a panic attack and having to explain to the tutorial leader 'listen I have to leave the tutorial because I had a panic attack. I've got schizophrenia. I get panic attacks'. So I had to explain it to her. that that was what the situation was.

Winston's psychiatrist recalled that this return to school was a very difficult year for Winston. but that his efforts were rewarded when he was one of only about fifty percent of the class to actually graduate.

Winston was accepted to university on the strength of his academic performance. but was unable to cope with a heavy and abstract academic load. the social anonymity and the lack of support. Concerned that he was unable to manage academics (*W: "My mind wasn't .. I was still shaky"*). Winston pursued training as a caretaker through a vocational rehabilitation program. but found himself experiencing frequent panic attacks and emergency room visits. The vocational rehabilitation reports indicate that the counselors questioned his employability and on their recommendations he began receiving a disability pension.

Dissatisfied with the inconsistencies between the type of work he was performing in the rehabilitation program and his desire to work directly with people. he terminated his involvement and returned to school. This time he pursued community college level studies and successfully completed a diploma in community work:

W: Academically, yeah. it was more easier. It was a lot easier. It was very interesting. It was just an easier experience academically. a lot easier. That was the major difference. So I just whizzed through that. It was just like another English course for me.
T: Really? And so it kind of tapped into all of your strengths?
W: Yeah. because I did 500 hours of field work. I had already done work in the field before. so that was easy. I had made connections in the community. so...it was just a logical step for me to take. You know if I can't hack it at university. take the community worker course at College. it's a two year program. it's a fast track to a diploma and to eventual work and that's what later it turned out to be.

Winston highlights the extent to which his work recovery during this time period was marred by the symptoms and impairments of schizophrenia and his relative lack of experience in coping (*W: "It's not like... I wasn't a vet at being ill. I was still really naïve"*). His feelings of paranoia would arise "*right out of the blue*", he was socially uncomfortable and "*very nervous of people*" and experienced a tremendous loss of self esteem, feeling "*not worthy of a relationship with anyone*". This period of coming to accept the diagnosis and treatment of schizophrenia coincided with gaining invaluable experience in learning to cope with the disorder. This included learning what to expect from mental health professionals and peers, the conditions for disclosure, targeting medications to alleviate specific symptoms, and self-soothing exercises to finish the job at hand without asking for accommodations from the employer:

> *W: I just tried to cope. I just tried to cope the best that I could. I tried to calm myself down any way I could by... I would get on the bus and go home and open a window and say, you're on the bus, you're on the bus, you're finally going home, you're gonna feel better in a little while.*

Stress on the Job

Winston takes a cautious attitude towards stress at work and its potential for exacerbating the symptoms of his schizophrenia:

> *W. I think if the job was too stressful there might be a recurrence of symptoms, I might start feeling flustered, hearing voices, things like that. That's why I've got to really watch what kind of work I do. My job is stressful at times. Sometimes there is a lot of pressure there but I've been able to handle it.*

Winston values the considerable training, the demands and responsibilities associated with his job. He highlights that not all aspects of the job that he experiences as stressful provoke his mental disorder. He has learned that work stress can exacerbate his mental disorder when situations lead to him to critical self evaluation:

T: So when does stress, which is part of your job, when does it become bad? Like when does it start to go over the top to maybe make you anxious?
W: When I start doubting myself. When I start losing my self-esteem, when I start thinking negatively about myself, that I'm a dummy that I can't do this or that.

Winston cites the example of becoming frustrated and unable to cope on an occasion when he was asked to work with residents who required direct nursing care. Although he experienced this situation as stressful, he viewed these nursing tasks as inconsistent with his skills as a specialist in community integration and subsequently they did not predispose him to a negative self view:

W: Well the nursing care, I'm not a nurse, I don't want to change diapers, I can't change diapers, I need to work with clients that are fairly independent that can feed themselves, clothe themselves, get up on heir own.

Similarly, Winston believes that he would have a high potential to "burn out" at his present job should he increase his hours beyond part-time. However he views this as an occupational hazard, as evident by the high staff turnover rate in his agency. He relates this to the constant demands of caregiving and a rate of pay that is only a few dollars above minimum wage.

Winston's self-esteem is threatened when he finds himself in environments or situations that trigger memories of the time when he was acutely ill, resisting treatment, living a skid row existence, and facing criminal charges. These situations produce feelings of anxiety that can quickly escalate into paranoia:

W: Right, right. That's the one thing the medication hasn't been able to do. It hasn't been able to alleviate really intense memories of deprivation and suffering.
T: And what you experience with that you said is anxiety?
W: Yeah, almost paranoid. I start feeling that people are talking about me or communicating to me when they're not, with their hands. You know all that kind of schizophrenic stuff.

These memories evoke intense feelings of physical and psychological vulnerability and present him with a view of himself that is not easily reconciled with a self-image of competence and well being:

> *W: It just brings back a lot of bad. bad memories. A lot of feelings. a lot of feelings of inadequacy. how inadequate I felt about myself. how down I was about myself. how much I suffered. I'll see landmarks. I'll see people that will remind me of these events and that's very disturbing.*

Winston rarely experiences this anxiety now and he attributes this to the general improvement in his mental health. anti-depressant medications and selecting environments that promote his mental health:

> *W: Yeah. Like I work in a nice. quiet residential neighbourhood in a bungalow. It's really nice and quiet. it's nice to sleep there. It's really nice and quiet. It's peaceful. all the houses are the same. well not the same. but it's a nice. quiet residential street where nothing happens and that's really soothing. You know it would be different if I was at the corner of that district.*

While the psychotic features of Winston's schizophrenia are generally well controlled. he experiences a persistent depression that hangs over him like a *"black cloud"*. This depression is characterized by feelings of apathy, futility and worthlessness. In response to these feelings. Winston sleeps for inordinate amounts of time. neglects his self-care. isolates himself socially and is prone to suicidal thoughts. He understands this depression as both a primary symptom of the schizophrenia and a secondary symptom. an internalized reaction to the stigma. the suffering and losses he has experienced.

Interestingly. it is his current experience of underemployment. related to his limited work hours and inconsistent schedule. that provoke his depression by leaving him with many unfilled hours to ponder his problems and experience a heightened sense of segregation from society:

> *W: If I can keep... if I had a full time job I might not need an anti-depressant. I don't know. I really don't know. that's yet to be determined. If I was busy all the time. but I'm not busy. I have a lot of time on my hands. After I'm through with you. I'm going to go home. I'm going to have lunch and then I have the whole day to deal with. so that's open ended so I don't know what I'm going to do. But if I had a job to go to or something like that. that would give me the structure and the substance to keep my mind occupied and to keep me from thinking and to make me feel worthwhile and to ensure that my self-esteem was high and my self-confidence was high.*

To cope with this inactivity. Winston actively imposes structure on his time outside of work. He attends appointments with mental health professionals and occasionally drops in at a day program at the psychiatric hospital. attends to self-care and home maintenance tasks. and listens to music. Recently he began a volunteer job delivering meals to the homes of seniors. He goes to sleep early. out of boredom. and sometimes lies down for a few hours in the afternoon. Winston maintains a job search to increase his work hours but several factors hinder these employment efforts. He finds that union rules at his present workplace favour full-time employees for vacant jobs. The most profound impediment he experiences is the stigma associated with the mental disorder. He experiences this stigma as both actual discriminatory hiring practices and an internalized assault on his self-concept:

> *W: The disorder has segregated me. excluded me from a lot of jobs for one thing. It's put me in a segregated position in society as far as work goes because of the stigma of mental illness. If I disclose especially. It's affected how I feel about myself on the job as maybe not as worthy or proficient as somebody else. even though after a while I tend to lose those feelings. but initially I feel very nervous. very un-self confident. thinking that I have to watch every step and every move I make.*

He is now applying for affirmative job positions for consumers of mental health services. He finds. however. that although these positions encourage disclosure and accommodate individual needs they are inundated with qualified applicants and are highly competitive.

Case Analysis

1.Work recovery is best understood from a life course perspective.

Approaching the case study of Winston from a life course perspective allows us to appreciate the important position that work has had throughout his adult life. even during periods of acute schizophrenia. psychiatric hospitalization and homelessness. Winston's experience does not so much represent a reclaiming of the lost worker role and the regaining of work function as

it does persistent drive and effort to succeed at work within the context of ongoing psychiatric impairment and disability. This life course framework allows us to focus on both the coexistence of, and the interaction between, work related activity and mental disorder throughout Winston's life.

His early work foundation developed in him both a strong identity as a worker and an appreciation for the stabilizing influence of work on his depressive symptoms. The stark contrast between this "healthy" self-identity and his experience of overwhelming psychosis and street life served as a catalyst for Winston's acceptance of the diagnosis of schizophrenia. This proclivity for work contributed to his motivation to control actively the psychotic symptoms of his schizophrenic illness by psychiatric treatments:

> *W: I was having a lot of panic attacks. I'd walk over from school to the hospital to see my psychiatrist nearly...well quite often to tell him "Listen I'm having an anxiety attack. I feel like I'm losing control. I don't know what to do. Is it the medication that is making me feel this way, or the lack of medication?" and he would up my medication by increments.*

Furthermore, in response to his work related efforts, Winston's primary treatment providers became invested in helping him and he in turn internalized their belief in his ability to succeed.

> *Psychiatrist's progress report: Work, active, no paranoia. Has been off medication for 8 weeks and feels growing confidence. I am not sure if I am over suspicious but I will watch for flattening of affect and restart meds if this occurs. Plans college in Sept. in community worker course. We must try to see that he remains fit to accomplish this.*

The life course perspective allows us to capture both the negative and positive elements of his present work situation. Certainly the limited number of work hours inherent in relief work leaves him vulnerable to financial dependency, to unstructured hours that provoke intense feelings of depression, and to threats to his self-esteem and hopelessness experienced within the context of the job search process. Yet Winston clearly describes his present job as a career and

the culmination of a series of related accomplishments that include a consistent vocational direction, the benefits of early work experiences in his chosen field and the legitimacy procured through the completion of a college diploma. While Winston is concerned about his career opportunities he remains hopeful that his current job is located within a broader career trajectory that includes both expanding his work hours and eventually completing university level studies:

> *W: Yeah. Not completely. I'm going back someday and get a BA. at some point.*
> *T: You still see that as something you could do?*
> *W: Oh yeah. I can do it. I can do the work it's just that I have to exert pressure on myself to apply myself to the work. I've got to make a concerted effort to sit down and do the reading and the writing. I've got to really discipline myself and I'm not disciplined. I've been leading an undisciplined life. I am going to go back.*

This positive meaning that Winston gives to his career is compounded by his experiences with schizophrenia. In addition to the enhanced personal benefits, he believes that his career success can also serve a public function. He perceives himself as a potential role model to inspire other individuals with severe mental illnesses to engage in work related efforts and to counteract the public stigma and indifference towards the mentally ill:

> *W: Yeah it could happen to anyone, yeah. I try to get...what I try to get across is that these people aren't numbers. These people you see on the street they are not numbers, they are not statistics. They are human beings with feelings, with desires, that want to be warm, that want to be fed, that have the potential to be really good people if given the opportunity and have the potential to do with their lives what I did with my life, because I was in the same boat at one time. That was me, the guy with the beard and the long hair, yelling on the street was me.*

2. Positive meanings attached to the worker role facilitate the individual's ability to negotiate the stresses associated with the worker role.

Several discrete dimensions of work related involvement combine to explain the significance it holds for Winston. He has the sense that through his community worker job he makes a productive contribution to society. Paid work represents the vehicle through which he

demonstrates his autonomy and self-sufficiency. He engages in volunteer activities with a view to connecting more immediately with his local community. Work activities widen his limited social network by providing him with a variety of social relationships characterised by equality and reciprocity. including collegial relationships with co-workers. mutually respectful relationships with supervisors and affectionate relationships with clients. In addition he has the sense work validates him within his family's value system and that it provides him with the legitimacy that was compromised both by schizophrenia and his criminal record:

> *W: My mother had a chance to see me go from off the street. dishevelled unkempt. lice. beard. long hair. not shaved. all this kind of stuff into somebody who was working and in the system with a diploma. cleaned up. all that kind of ... like completely...completely changed...completely rehabilitated and that pleased me a lot because I wanted to show my mother that I could do that. It was really important for me to get that job because what it gave me...it gave me legitimacy. I had a criminal record before then.*

Winston describes his return to pre-university studies as an act of "*desperation*". In addition to his belief that without academic certification opportunities in his chosen field were limited. Winston believed that the stigma surrounding both the mental disorder and his criminal record would compound his loss of employment potential. Unwilling to accept the identity of mental patient that he saw as the outcome of the loss of future work. Winston directed his efforts to achieve at school despite the presence of disturbing symptoms. considerable functional disability and the significant assault on his self-confidence that marked his early experiences with schizophrenia.

It is important to note that Winston committed his energies towards obtaining work. While he initially directed his academic efforts towards university level studies. he viewed school mainly as a vehicle to achieving his employment goal. This provided Winston with the mental framework necessary to frame his inability to master university level studies as the result

of a "*poor match*" between his own needs and the academic program rather than as a personal failure. This idea of finding a good match is a prevalent theme throughout Winston's work life and reflects his persistent tendency towards self-direction in the presence of significant psychiatric instability and functional impairment. Winston himself stresses the importance of the availability of a variety of work related options to meet individual needs:

> *W: I thank the educational system in Ontario for that. The fact that you can go to university or college, that there is a choice. Because not everybody's cut out for university, not everybody's cut out for college, there's a choice and if it wasn't for that I wouldn't have my diploma because I don't think I could hack university.*

Beyond his more generalized commitment to work, Winston had a longstanding direction to work with people within the social services. While this career interest appears to have begun in his adolescence in response to his dislike of the sciences, it has grown in significance to represent a "*noble*" choice, that exonerates his sense of suffering and victimization surrounding his mental illness. It has also satisfied his desire for affectionate and respectful social relationships and for a connection with his community, both remarkable features given the social aversion and isolation typically associated with paranoid forms of schizophrenia.

The meaning that Winston placed on this specific career goal appears to have played a crucial role as a mediator in the relationship between the schizophrenia and his work functioning. During a particularly disruptive period in his early experiences with schizophrenia, Winston requested and became involved in vocational rehabilitation services to assist with a change in vocation to a trade. He was involved in a variety of work trial placements in dishwashing, audiovisual and lighting, appliance repair, upholstery, clerical, printing and finally settled on janitorial work. While his motivation for work remained high, he experienced strong feelings of dissatisfaction and symptoms of anxiety, panic and paranoia that interfered with his ability to

perform on the job and provoked drop in visits and telephone calls to the emergency department of the psychiatric hospital. In response to these difficulties his rehabilitation practitioners appear to have generalized the implications of these functional difficulties to preclude a return to the human services:

> *Rehabilitation services report: His paranoia and inability to cope with high levels of interpersonal stress are factors that make a career in community social service work inappropriate. His aptitude and interest in mechanical/repair activities would be a more appropriate avenue for rehabilitation.*

Dissatisfied with the vocational choices offered through the rehabilitation services. Winston withdrew and on his own enrolled in college to complete the community worker course. This initiative was characterized by a marked decrease in anxiety and emergency room contacts. an increase in coping efforts within the context of the work setting and a general sense of well-being:

> *Psychiatrist's progress report: He sees himself functioning at his highest level now over 3 years. Looks and sounds happy with his life.*

3. A central feature of work recovery is the individual's perception that it is possible to create a functional self-identify separate from the disorder.

Receiving a diagnosis of schizophrenia presented Winston with a significant threat to his self-identity. He found the events surrounding the diagnosis, including involuntary commitment. criminal charges and convictions. abject poverty and homelessness, to be extremely frightening and inconsistent with his personal intentions. He believed that the diagnosis placed the source of the problems within himself without due consideration for the contributing role of ongoing family conflicts. In retrospect. Winston believes that the process leading to his acceptance of the diagnosis was problematic because it failed to provide him with a balanced interpretation of events:

W: I think I would have accepted the diagnosis easier if it could have been said that Winston, you've got schizophrenia, you've got serious problems but we also think that your mother and brother have some problems too.

Rather than engagement in a process of engulfment into the role of mental patient, Winston resisted the medical interpretation of his problems. He maintained a measure of control over his daily life and his future direction by taking on the role of a student preparing for work in the human services. The role of student allowed him to take significant steps towards his vocational goals and to manage interfering aspects of the schizophrenic disorder within an open, supportive and accommodating environment. It also allowed him to conceptualize the experience in a normalized framework, by defining himself as a disadvantaged student:

W: I found that to be a very, very, difficult course and it's not for everybody. There's a lot of reading, there's a lot of studying, there's a lot of writing, but it's the kind of course that was tailored just right for somebody like me because it is so supportive. It is emotionally, financially, socially supportive of people who are like me, who are at a disadvantage economically, socially, psychiatrically, or whatever, it is a highly supportive program.

Several factors appear to have disposed Winston towards a self-directed orientation in the wake of the distressing events associated with the diagnosis of schizophrenia. These factors include his: i) positive response to an anti-psychotic medication; ii) early work foundation and: iii) financial independence.

i) Accepting medication

Winston is adamant that the single most defining factor in his work recovery is his acceptance of, and positive response to, psychiatric medications. Although the medications do not completely eliminate the disabling influence of symptoms on his work, they do ameliorate them to the extent that Winston is able to actively employ coping efforts to manage work related demands. He continues to experience, in response to specific environmental features, the

feelings of personal threat associated with paranoia. However the anti-psychotic medication lessens the intensity of the experience. They maintain him in a mental framework that allows him to evaluate the reality of his experience and to employ coping techniques, such as self-calming or avoidance, within the context of fulfilling his job responsibilities. Beyond their maintenance functions, Winston strategically manipulates his own medications to target specifically the anxiety that can rapidly spiral into the full fledged experience of paranoia.

While the control of psychotic symptoms was particularly relevant during the early years of the schizophrenia, the use of anti-depressant medications to control his depressive symptoms has now become the priority. Unlike the psychotic symptoms, the depression does not appear to interfere directly with his ability to work, but rather leave him vulnerable to suicidal thoughts and subsequent admissions to hospital. The medications lessen the impact of his depression, particularly during the unstructured hours away from his work, to allow him to cope:

> *W: I'm lucky, I'm lucky. I respond really well to the anti-depressant I'm taking because if it wasn't for the anti-depressant I would have done myself in long ago I'm sure cuz I was getting really, really down... really suicidal. That's all I was thinking about and I've been out of hospital for two months now and I haven't thought of it. I've been able to make it through the weekends. I've been able...sure I'm living at a really high level but I am coping and that's one thing that couldn't do before. I couldn't even cope. So the medication is allowing me to stay in the ballpark.*

A complete understanding of Winston's acceptance and positive response to medication necessitates an appreciation of his freedom from their disabling side-effects. The protracted nature of his acceptance of these medications can be at least partly explained by the presence of side-effects that interfered with his interest in work related activities:

> *W: I really hated Largactil because I was one who like to read papers a lot, that's how I got into [the university preparation course]. I was reading the newspaper one day on the ward and there was a short article on [the course], all about how it might be cut off because it claimed to be Marxist oriented ..., so I heard about it through reading about it on the ward... Hey, this is a way of getting into university without taking, you know*

courses at night school and all this kind of stuff, but I couldn't read because of the Largactil, my vision was blurred and that really bothered me.

It is this acceptance and positive response to medication, rather than the relative severity of his schizophrenia that distinguishes Winston's success in the area of work recovery. The severity of the acute presentation of his schizophrenia was frightening for Winston, and a startling contrast to his experience of well being. He maintained an active stance towards his mental health problems, implementing radical lifestyle changes in an attempt to gain control of his own well being while maintaining a self-image of competence and credibility. The dramatic decline in his life condition in spite of these efforts appears to have served as a catalyst for his acceptance of psychiatric treatment.

Furthermore his positive response to Modicate does not represent an absolute response to psychiatric medications but rather the outcome of the effort of his primary treatment providers to individualize his care, to find the medication that would concurrently control the impairing symptoms of his schizophrenia while facilitating his ability to function at work.

ii) Early work foundation

Winston's early work related experiences occurred within the context of an atypical family situation that demanded his active participation in employment from a very early age. Interestingly, his father's schizophrenia appears to have contributed to Winston's early work experience, both by requiring Winston to work extra hours to compensate for his father's episodes of dysfunction, and also by providing Winston with a role model of an individual who attained a measure of work success in spite of a diagnosis of schizophrenia:

W: Any wealth that my family has accumulated is directly attributable to my father's strategy in business.... My mother basically lived off the wealth that my father created.

Family dynamics abbreviated the developmental process of autonomy and self-sufficiency for Winston while continuing to impress upon him the value of achieving conventional measures of success:

> *W: They just didn't understand what I was doing. All they could think of was in terms of going to professional school and getting a BA. They couldn't see any other alternatives to work or running one's life other than the standard. getting out of high school. going to university and becoming a professional.*

Furthermore, his early departure from the family home facilitated the development of social contacts that provided him with both real work opportunities in his chosen career field and with the positive experience of acceptance in spite of his differences:

> *W: Well I knew Bob so I said. 'Bob listen I need a job'. Bob and I had been friends. He had been one of the childcare workers at my group home that I'd gotten close to and we had become good friends. He had been very supportive. I told him I needed a job. and what can I do? I've got long hair and nobody wants to hire me. you know... why don't you try coming over and working at child services.*

His exposure to several entry level social service jobs provided Winston with the opportunity to receive positive feedback about his aptitudes and abilities in his chosen field. It also allowed him to refine his vocational interests. He developed a clear sense of self-identity in the work realm and this later provided him a purpose and a direction that both motivated and guided his recovery efforts:

> *W: Because I know what I wanted to do. I knew what I wanted to do with my life vocationally. I knew what I wanted as far as work went.*
> *T: You'd already made a choice?*
> *W: Yeah. I'd already made a choice. I was successful at it. so I went back to it later on when I got better. I think that's an important thing to think about.*

This commitment to work in the human service field was enhanced by Winston's understanding that he had been accepted in the early jobs despite his personal problems and atypical appearance and that his lived experiences were actually an advantage on the job. In

addition. his early impressions of himself as a "*role model*" continued to develop and eventually served an important function in helping him to resolve his sense of guilt about his own recovery and financial prosperity relative to others with severe psychiatric disorders. It evolved into a belief that his participation in work served a broader public function including public education about the plight and the potential of people with mental disorders and inspiration to others with backgrounds similar to his own:

> *W: Well, I don't consider myself as a leader, but more of a role model for other people. If I can do it, if the guy with the beard and the long hair that used to sleep on the sidewalk at the corner of such and such a street graduated from a university preparation course... I took that newspaper article about me to the mission by the way about a year ago. I gave it to somebody there and they hung it up on the wall. I told them that I used to eat here and I graduated from the academic program, so this is what the guys can do if they ever put their minds to it. If that same guy that used to sleep on the sidewalk with the beard and long hair can do all that, then maybe you can do something too. That's my story.*

It is also important to consider that Winston's history does not represent a sudden, or wholly unprecedented descent into mental disorder. Although the events surrounding his first contacts with a psychiatric hospital and his diagnosis of schizophrenia illustrate a startling and rapid process of mental and psychosocial decline, these were predicated by several lengthy periods of intense depression. Whether this early depression was directly related to the advent of schizophrenia is unclear, but it did place Winston in the position of managing the demands of employment while experiencing significant mental health impairments. Winston did not perceive this early depression as exerting an inordinate strain on his ability to fulfil the essential tasks and responsibilities of his jobs. Rather the depression engaged him in the dilemma of experiencing work as a simultaneous source of stress and of well being. Thus it provided him with the early experience of negotiating a sustained commitment to the worker role in the midst of a significant and protracted disturbance in his mental health.

iii) Financial independence

Winston's induction into the system of disability related financial benefits, posed a significant threat to his ability to recover a functional self-identity within the realm of work. Despite his successful performance at community college and the clinical benefits associated with his participation in academics, the severity of his disorder and the related protracted period of psychosocial instability apparently called into question the likelihood that he would ever recover the ability to work.

> *W: Yeah, I got better, I got better, it was a miracle. I still believe that it's a miracle that I did get better, because if you had seen me, like I said, if you would have seen me then and see me now, it's total... two totally different people. So my admission into the FBA program was legitimate and was deserving, but nobody realised that I would do so well on the medication and eventually find a job. Nobody knew that. I mean that was totally unexpected*

The financial security of the benefits tempered Winston's impetus to begin working even after a sustained period of compliance with psychiatric medications, significant improvement in his mental health and completion of a college diploma as a community worker:

> *W: Oh yeah, it was more money. It was more security. I didn't want to go off it. I know what my thoughts were about it. I certainly didn't want to go off it. It's a tremendous amount of security. I had to be pushed to get off it.*

While the regulations relating to the disability pension allowed the collection of an adjusted financial allowance for part-time work, negotiations with the disability office became a source of stress for Winston. They reminded him of his past contacts with the law and provoked a fear of potential legal involvement. The subsequent distribution of the assets of his family inheritance provided Winston with the financial autonomy necessary to terminate his disability benefits and at the same time encouraged a normalized self view:

> *Note from medical chart: Off FBA. Patient spoke of relief and shift in self-image from sick role as patient to being a healthier person.*

Although he experiences his economic situation as constrained. his financial situation does provide him with the freedom to maintain part-time employment. His current psychiatrist identified Winston's financial independence through the family trust as a critical element of his work recovery because "*...there is no need to label him as unemployable for his financial well being*".

4. **Internal locus of control, self-esteem and commitment are psychological factors associated with work recovery.**

Winston's work life is characterized by images of an individual who remains an active agent in creating a personal identity that is acceptable within a normative ideal of social roles and integration. He is both described and describes himself in language that depicts him as an underdog. a casualty of an unfortunate serious of events. who fights and struggles against all odds to achieve a respected and meaningful place in society.

His tenacity appears to be directed towards those experiences that particularly threaten his self-esteem and self-confidence by increasing his sense of social marginalization. This includes those situations that evoked in Winston the sense that he was the victim of an injustice. This struggle was demonstrated as rebellion in his adolescent years in response to the constraints imposed by his family (*Winston's childhood friend: "He always was a bit of an upstart"*) and was translated into resistance to psychiatric interpretations of problems that he understood as a family conspiracy and victimization by the legal system. Winston's strategy was to adopt a more normalized self-view as disadvantaged and to vindicate himself by becoming successful in the realm of work according to the standards of his family and mainstream society:

W: So when I felt that my rights had been taken away or been dealt with flimsily I felt I had to fight back and show them that sure I've got a criminal record but I can go to university. I can go to college. Sure I'm schizophrenic. I can still work a little bit. I can fight back. I can do some things.

Winston appears to have been particularly adept at appraising his own abilities and resources in relation to work related activities while selecting vocational options that were both achievable and personally meaningful. For example, he was able to recognize his functional disabilities during his early experiences with schizophrenia, even though he was resistant to accepting the diagnosis and the recommended treatments. His decision to attend the university preparation course while experiencing significant mental instability allowed him to frame his functional problems in a normalized context, while securing the support and the environmental accommodations that would facilitate his ability to perform academically. In addition he viewed the academic program as consistent with his own work goals and its organization and structure as consistent with his preferred self-identity as a mature student.

Winston credits his persistence to a "*mental flexibility*" that allows him to appraise failure situations without submitting to disempowering explanations for the source of the problem. Winston perceives failure as inevitable, but for most failure situations he sees that there are alternative options to pursue. While he believes that the schizophrenia left him more at risk for failure, he considers the experience of failure to be universal and indicative of a poor match between the person's interests and needs and the situation:

W: I know a lot of people wouldn't be able to do that. It wasn't just me. If it was just me and ... you know, it would be different. So I felt that I just wasn't suited for it, and that's all, it wasn't a good match. You know life is a very wide spectrum of types of things that one can do and you've just got to get lucky or...or... to find the right one, you know?

In addition, he stresses the importance of trying work related activities, despite the risk of failure, in order to experience the positive impact of even small accomplishments on self-esteem and self-confidence.

Reinforcing his struggle and his self-image, Winston received considerable support from legitimate social sources. For example, Winston's psychiatrist became highly invested in assisting him to develop his work life although they disagreed about the definition of his mental health problem (*Psychiatrist: "I was more excited than he was"*), and he was featured in this excerpt from a public interest story that appeared in a national newspaper:

> *Winston had been out of work for a year and a half and on welfare for six months when he was admitted to the pre-university academic preparation last fall. With only a grade 11 education 'my future looked pretty bleak' he says. 'I just couldn't get a job anywhere.' Winston's prospects have improved dramatically after one year in the program designed to prepare bright dropouts for university.*

Although the impetus for this social support remains unclear, it appears likely that to some extent Winston's personal qualities of determination and resolve served to capture the attention of significant others, highlighted his potential and subsequently exhorted them to action on his behalf.

5. The individual's perception that valued people believe in his/her potential is associated with work recovery.

Winston's credits professionals as the most important source of social support for his development in the realm of work. This primary position of professionals in Winston's life is understandable given his early separation from an established network of family and friends. While he mentions professionals from a variety of helping disciplines, they possessed common qualities that Winston experienced as instrumental in supporting his process of work recovery.

First, he experienced these professionals as listening to him and conveying their understanding of his perspective. They demonstrated this by assisting him with his efforts and maintaining their commitment to him throughout his early struggles with schizophrenia. Winston remembers this as having a powerful effect on his belief in his self-image and self-worth by reinforcing the normalized view that he was essentially a functional person dealing with a difficult impasse in life:

> *W: Well they seemed to have more confidence in me than a lot of other people had. More confidence and they seemed to be like really decent and saw me as somebody that was going through a phase of problems and it wasn't going to be a perpetual mess, like always a problem, somebody that was going through a phase, somebody that was sick or whatever and needed treatment.*

Second, their authority placed them in a relative position of power that they used to influence others to support his efforts in the work realm. So in addition to their encouragement and moral support, Winston trusted them to use their authority to effect real change in a manner that was consistent with his own needs and desires:

> *W: It's a gut feeling, it's just a feeling I get from people. They they're decent people, that they're not going to try and take advantage of you when they could, when they easily can if they wanted to. They are obviously in a position of power and you are asking them for something and they are probably going to give it to you.*

Third, they were individuals who interacted with Winston in a manner that deprofessionalized the relationship by allowing an exchange of their relative strengths and weaknesses. This, in turn, contributed to his perception of his own self worth by reaffirming that both negative qualities and positive qualities coexist within humanity.

Finally, they were people who honoured him by providing him with opportunities to demonstrate his strengths and abilities in ways that he considered socially meaningful. For example, he has been asked to join advisory committees within the mental health system, to

speak at public education events, and to participate as a consumer interviewer for a research project focusing on people with mental illness.

Winston's informal social network is exceptionally small and he is generally dissatisfied with his social integration. He identifies a childhood friend as playing a particularly instrumental role in his work recovery by maintaining their relationship throughout the events surrounding the schizophrenia, providing him with practical information, and encouraging his work efforts by serving as a positive, normalized point of comparison:

> *Winston's childhood friend: At the time he had completed grade 13 and was trying University and he was depressed because he couldn't do the university. I said I couldn't do it either. It's economically very draining and it's mentally taxing. I said community college is cheaper and it's training, like an apprenticeship.*

6. An integral feature of work recovery is the individual's appraisal of employment as essential to mental health and well-being.

Winston credits his participation at work as being a longstanding and pervasive source of his personal well-being. He views work as instrumental in facilitating his self-sufficiency and subsequently his autonomy from family conflicts. He believes work provided a source of stability and hope in the midst of his early experiences with depression:

> *W: I just did it. Work was a stabilizer. Work was the best thing happening in my life. I knew it. The work's always been a stabilizer for me. If I could only get work, it would give me something to do, keep me busy, keep my mind occupied, give me some money. Work was always a stabilizer. Work always made me feel good. It made me feel productive. And working as a child care worker was a really hard job. That's really hard work, I would never do it again.*

In his adult years, work has provided a stable source of social contacts, money, meaningful activity and social legitimacy. In addition to contributing to his general sense of mental health and psychosocial well-being, Winston believes that his involvement in work has had a direct, positive impact on his schizophrenia. For Winston, medications have played the

primary role in controlling the psychotic symptoms of the disorder, but work has lessened the severity of the disorder by impacting on its depressive qualities. It does this by structuring his time to direct his thoughts away from endless hours of self incrimination and challenging the beliefs and assumptions that underlie and aggravate his internalized sense of stigma:

> *W: Lessens the stigma, for me, my own personal stigma and how I feel about myself having schizophrenia. There's two types of stigma I think. One's personal stigma...one's ... about how one feels about themselves, having this illness and there's a stigma that society places on you. The stigma I'm talking about there is the stigma that I place upon myself having schizophrenia. It's lessened that. I feel more of a normal person. I feel more of a capable person, that I'm just as good as anybody else.*

Summary

This chapter has presented the case description and analysis of a forty-four year old man diagnosed with paranoid schizophrenia who has been employed for thirteen years as a relief, residential counsellor in a group home for seniors with developmental delays. While the case is in many ways consistent with the theoretical propositions, it suggests the need for refinements to existing theory.

The life course perspective captures the extent to which Winston's actions have been directed to employment, even during periods of acute illness. The case study evidence suggests that the theoretical propositions deal inadequately with the experience of schizophrenia as an ongoing issue within the work context. In fact, Winston's case does not provide evidence of the development of a self-identity that is separate from the disorder. Rather it indicates that central to the work recovery process was his recognition that maintaining a functional self-identity was dependent on his acceptance of the schizophrenia diagnosis and on his efforts to directly negotiate features of the disorder within the work context. While collaboration with professionals on biomedical interventions was a cornerstone of the recovery process, he was also faced with

the challenge of reconciling several psychoemotional issues, such as disclosure of the disorder in the workplace, internalized stigma that undermined confidence in his credibility as a worker, and guilt over his relative level of work success compared to others with the disorder.

Personal characteristics that facilitated Winston's ability to persist with work related challenges included: a flexible goal orientation; understanding his work struggles as a process of growth and as a universal phenomenon; altruistic actions on behalf of individuals with mental illness and; learning to actively manage the interaction between psychosis and work. Extant theory fails to address the specific interactions between work and schizophrenia and subsequently fail to provide a framework for active coping with work related challenges.

Consistent with the theoretical propositions, the positive meanings that Winston associated with work served as powerful motivators to sustain involvement in work. Perhaps the most powerful motivator was Winston's belief that work was essential to the stability of his mental health and well being. Winston's case illustrates that work can be invested with positive meanings and simultaneously perceived as a threat to well being weakening the resolve for work. In this case study the negative implications included financial instability associated with disability pension policies and inconsistencies between his personal values and work.

The theoretical propositions do not account for the role of early work experiences in the process of work recovery. These experiences instilled in Winston a sense of vocational direction and a strong work ethic based on the values of self-sufficiency, autonomy and achievement. His early work experiences facilitated his acceptance of the illness by providing a stark point of comparison for his social deterioration. His early impressions of his father working in spite of a diagnosis of schizophrenia also provided him with a role model for employment and mental illness. In addition, Winston's longstanding and pre-psychosis experiences with depression gave

him the experience of managing the work-illness interaction, and of being accepted as a credible worker in spite of mental health problems.

While ideas about recovery have focused on change at the level of the individual, the case study highlights the extent to which events at the environmental level can influence work involvement. These events can be located within the individual's immediate environment (as the case of the family inheritance providing Winston with the financial stability he required to work), or broader social changes (such as the advent of affirmative employment opportunities for individual with psychiatric disorders). As expected, the social network played a prominent role in the process of work recovery. It is noteworthy that this was largely comprised of mental health professionals. Winston's process of work recovery was positively influenced by his perception that credible professionals understood his perspective on his struggles. They enabled his sense of self worth by using their power and authority to create real work opportunities.

The case study presents work recovery as a career trajectory that continues to evolve. In fact it suggests that the term "work recovery" may not adequately represent Winston's relationship to work. Although work recovery describes a desirable level of change or progress in work function, it suggests the culmination of a progression of changes. Winston's career reflects growth and a series of accomplishments that he hopes will continue in the future. Yet, he continues to deal with issues relating to the work-mental disorder interaction that undermine his employment status.

CHAPTER 4

CASE STUDY 2: ANN

Case Description

Just a person with an illness

As the sole clerical float in a health records department of a large general hospital Ann's primary job function is monitoring medical charts to ensure they are complete. Her job requires the flexibility to perform this task across several different services. each with its own specific requirements and procedures. Depending on the specific job assignment. Ann's responsibilities can also include locating and delivering charts for the hospital's clinics. using special business equipment and computer programs and telephone reception. Ann has been employed within this health records department for the past twenty years. Her performance on the job has been exemplary. She is a dependable employee and has adapted well to the versatility of routines required by the position. While her productivity rate is within acceptable standards. she is particularly recognized for her meticulous attention to the details of clerical monitoring :

> *Ann(A): Yeah. it meets the requirements. That's always been...I think because I'm so conscientious that it slows me down because as the Director told me. I think I told you. this girl that's coming from the other hospital to learn checking. The Director specifically asked me and she said it was because she said. Ann I know that you are so careful in details about how you do your work that I want you to train her. So that was a compliment.*

Ann was hired into this job when her psychiatrist. who worked for the hospital. asked the Director of Health Records to interview her for a job. The Director hired Ann into a vacant position aware that she had experienced emotional problems. Three years later. while on the job. Ann had her first full blown episode of psychosis that included the uncharacteristic use of

profanities (*A's coworker: "First thing that tuned me in is she started to swear right out of the blue"*), peculiar behaviours (i.e. walking backwards) and religious delusions (*A: " ...I think I'm the Lord Jesus"*) that totally preoccupied her social behaviours (*A: "I lose contactability"*).

Ann experiences the disclosure of her schizophrenia on the job as a relief. It provides her with the freedom to describe her behaviours as a manifestation of an illness, when a situation presses for an explanation:

> *A: I'm on a strict diet because the medication I'm on, one of the side effects of it is weight gain, so I'm on a strict diet and of course they ask why because they say, " You know, you don't look fat what are you dieting for".*
> *T: Because you're not at all, you're really slim.*
> *A: So I tell them that this medication I have to take, I take for a chemical imbalance in my brain. This is the side effect of the medication. This is why I have to take it, for schizophrenia.*

The outcome of this above-board approach has been a general sense of relief and the experience of acceptance and validation despite the illness:

> *A: Actually it's a load off my shoulders because I feel like if I was working and they didn't know and I was hiding something, I would always have to watch what I was saying. This way they know, I don't have to act, I can just be myself and from that I will explain. Like when I was 18 I was in a sanitarium. I learned what it is to be a mental patient and I felt like I was a freak and that type of thing and through it coming out in the open when I was 29 and they saw me in a state of bizarre behaviour and then after when I was put on medication and became well, even though I'll always have it and it has to be controlled, they still treated me the same, they didn't shun me or anything.*

The Work/Illness Interface

Ann finds that her learning abilities are affected by frequent spells of *"disassociation"*, a sense of being separated from herself while she is performing work tasks *(A:"I'm looking down on me functioning but it's not really me doing it")*. These spells interfere with her ability to take in and retain information. She highlights that she has never fared particularly well in traditional

classroom settings and that these factors have interfered with her efforts to complete upgrading courses related to her job:

> *A: I'll say it's been two years now and my older sister and her neighbour. the three of us signed up for a computer course at college. Well it just became so overwhelming for me I just dropped out. I didn't complete it. And it was because I think I didn't have one on one training on the computer. Like the teacher just said something and left us on our own to figure out how to work the computer ourselves. And I wasn't able to cope with that so I dropped out. It was discouraging for me.*

She learns best in the context of a one to one relationship where the new tasks are broken down step by step. where she can observe and practice tasks and can take notes to aid her retention. Ann depends on coworkers for advice and clarification with ambiguous tasks. Ann's job environment has naturally accommodated her individual learning needs by providing direct training on the job.

Although the symptoms of the schizophrenia are controlled by medications. Ann experiences "*break through*" symptoms and medication side effects on the job. She manages these without the knowledge of her coworkers (*A's coworker: "She can have little symptoms that we're not aware of.*"). Ann experiences hallucinations on the job once or twice a day. She is aware of her distorted visual perceptions and employs self-monitoring techniques to manage them:

> *A: ...going upstairs or maybe to pick up charts, you know how sometimes they have an apparatus in the hallways like a Stryker bed or something like that. when I first see it. It'll look like a skeleton and I'll turn around and look back and it's gone and I just continue on doing my job. I don't let that frighten me or think I'd better go home or you know.*

Auditory hallucinations are more frequent and are more complicated then visual distortions to manage. Ann will hear people refer to her in a religious context. Although she is aware that this perception is related to the mental disorder. the social dynamics of the workplace

make it particularly difficult for Ann to interpret these as hallucinations. She works in an open environment with forty coworkers in close proximity and there are frequent interpersonal conflicts (*A: "...as soon as one turns they talk about them, they're constantly criticizing each other behind their backs and all that kind of thing"*). In addition, Ann believes that her social abilities have always been limited, a situation made worse by early and lengthy periods of institutionalization *(A: "Although like I said in the social side I'm really poor. I'm stuck in a groove there").*

Ann is particularly sensitive to interpersonal conflicts. When the resolution of an interpersonal work problem does not allow for ignoring social friction she states that she experiences a *"heaviness in my heart"* that will actually trigger an increase in hallucinations. Even those work problems that appear to be task related are experienced as stressful primarily because of the nature of the social demands underlying the task. For example, in the wake of the recent restructuring of the health records department, Ann was asked to work at a job that had traditionally been managed by two people. She found the pressure of the workload beyond her abilities, but she was particularly concerned about interacting with a supervisor who she anticipated would be sarcastic and ineffective in communicating a response to her requests for job clarification.

Ann's strategy to deal with these social pressures is to maintain a friendly but detached social stance and to neutralize her interpretations of social situations:

> *A: I treat them all the same. I'm very nice to them and I don't... I'm not a backbiter, you know I'm just kind to all of them. Like if I have to do a job with any one of them I just you know do what I have to do and be pleasant. I very rarely am ever angry or upset or you know, about what somebody might be saying or whatever and that's one thing, even though they may be talking about me and I hear something and I'm not quite sure if I've actually heard it or not so I don't act on it.*

She is open about her illness with coworkers without focusing on it as topic for social conversation. She has managed the acute episodes of her illness on the job by informing her coworkers about the nature of her problems and openly reconciling any social transgressions. This appears to have endeared her to her coworkers:

> *Ann's coworker: When she came on strong it upset me a bit. Then she was hospitalized. After, she phone me. She is very bright when it comes to her illness. She phone me and apologized. I was amazed that she could remember...She talks about it even with new staff. She has won the heart of all of us.*

To assist her with these social strategies she seeks out the perspective of mental health professionals *(A: "[My psychiatrist] told me that this happens and said not to...just go in and be nice to her...not cause any conflict")* and she tries to frame her responses to situations to be consistent with the principles of her strong Christian faith *(A: "How a Christian would handle it but not like say if they do something I'm going to get them, or this type of thing, you know what I mean?").* She also tries to understand the nature of these work problems from a perspective that balances the contribution of symptoms with the likelihood that they are universally experienced by her coworkers :

> *A: And I'm not the only one who feels that way, the other girls feel that when they're being pressured to do more than their own job. They quit and find something else, but I'm not going to quit my job for that.*

Ann is particularly cautious in her approach to managing the appearance of delusions. She has learned to seek her psychiatrist's assistance with medication adjustment at the first appearance of delusions because they escalate quickly to a total loss of contact with reality:

> *A: Yes, that's right and I've gotten to learn now that as soon as I think I'm the Lord, of course, I know that the illness is there now. It's the same...it's the same thing. And it effects all of my five senses, my sight and my hearing and everything.*

In addition to upsetting her relationship with her coworkers. she finds that the delusions create an aftereffect that impacts on her work performance for several months after an intense episode:

> *A: Just the delusions. they are so real it takes a while for the effect to go away from having had one and it's just going around thinking to myself. I think that really happened.*
> *T: So it follows you on the job?*
> *A: It follows me on the job for about two or three months after I've had a severe attack. So I have to cope with talking to the girls at work and letting on that nothing's going on and doing my work. It's a real difficult thing to do.*

Learning to be a mental patient

Ann struggled with the academics from the beginning of school:

> *Grade One Report: Ann has been having considerable difficulty with reading. sight vocabulary and number work. She also has difficulty recognizing words that begin with the same sound. I'm afraid Ann is going to require more than the average time to complete Grade One.*

With remedial work she was able to maintain low average grades. although she remained quiet and withdrawn from the flow of the classroom *(Grade Six report: Although Ann's marks have remained fairly constant. she spends too much time in "her own little world").* In retrospect Ann believes that she began experiencing symptoms of her mental disorder as early as eight years old:

> *A: But it would be like say at 8. 9 and 10 I'd walk to school and when I'd come home I'd have to walk the exact same way back home. Like if I went through... like if I was walking through the school yard and there was a soccer net up and I went around it one way. I'd have to go back the same way that I came and like I couldn't go to the other side because I had to follow the path I had taken.*

Although never formally diagnosed at this early age. she experienced herself as *"different"* from her peers:

> *A: I'll tell you one thing when I was in kindergarten and I really believed it. I used to think. I used to feel that I'd come from another planet almost like I wasn't like everybody else.*

She first became aware of having mental health problems, specifically feeling withdrawn, depressed and having suicidal thoughts, at the age of age of twelve *(A: "I thought well maybe it's just a part of going through the puberty you know, but it turned out it wasn't, it was I was not well").* Unable to meet the academic requirements of high school's academic stream, Ann transferred into the shorter, business program. Her personal vocational goal was to eventually prepare to become a nursing assistant.

Despite these problems Ann remained socially connected with school and her local community. She excelled in competitive athletics and she reinforced her interest in the health care field by serving as a volunteer candy-striper at a local hospital. She also managed to hold summer jobs helping out in general stores.

By grade eleven Ann's depression had increased to the point where she was unable to function in the classroom *(A: "I sat in the back of the class and wouldn't even write the test and they never phoned my parents and told them").* Ann was admitted for three months to a psychiatric hospital, her first of several hospitalizations between the ages of eighteen and twenty three (*A: ...I know like between the ages of say eighteen and twenty one I was in and out of hospital all told about a year*"). These years had a devastating impact on her psychosocial development. Her feelings of being "*different*" were magnified to feeling like a "*freak*". She recalls this as the darkest period of her life, a time in which she was overcome with feelings of despair and hopelessness.

Institutionalization separated Ann from the structure of her daily routines and goal directed activities without providing an appropriate replacement. While she enjoyed the craft activities available in hospital she states there was "... *nothing concrete to help me with further*

managing once I left the hospital." Her treatments with medications and electroconvulsive therapy did not relieve the depression and she made several serious suicide attempts.

Ann attempted, independently, to reconstruct a social and work oriented life but these efforts were largely unsuccessful and reinforced her growing self identification with the label of "*mental patient*". She found that her few friends terminated their contact. She returned to high school after her initial hospitalization, but was unable to manage the academic demands:

> *A: I just didn't think I could do it. The work. I was so depressed and to study I just couldn't retain anything or, you know, the actual work itself beyond any...it was overwhelming.*

She also experienced blatant discrimination in hiring practices based on her psychiatric history:

> *A: I went to an A&P store and they had advertised a job for a meat packer and so I went and applied for it and the manager didn't have the application at the time. He had run out. But he said you can start in a few days. So I went to another A &P store where friends of my parents worked and I got an application form, filled it out and took it in, and they asked on the application form if I had ever been in a hospital or had a major mental breakdown, was I think the wording. And I wrote down, I was honest, and said I had and I took it into him and when he read that he said to me I don't want you and I went out of there crying. My dad was so upset he called the President of all A&P stores at that time and he phoned the store manager and the store manager called back and said I'll give you a second chance, but I said no.*

It is important to note that Ann was not diagnosed with schizophrenia at this time. In addition to depression, the medical reports available from this time include diagnoses of severe emotional maladjustment, neurosis and immature personality. Ann experienced these interpretations as particularly disempowering because they personalized the source of her problems (A: "*I though it was something that I had done that caused it upon myself, my actual psych...my personality*").

Work as a context for recovery

Ann identifies two major turning points that initiated her active efforts to facilitate recovery. First, in response to a very serious suicide attempt at the age of 23 Ann became a Christian, an option that had been introduced to her by family members and her physician. Her acceptance of this spiritual philosophy coincided with a referral to a community vocational rehabilitation service. This was the first time that work rehabilitation was directly addressed by mental health professionals. Ann credits these rehabilitation services with engaging her in daily routines that demanded effort but were, at the same time, manageable:

> *A: Just to get up in the morning and have something to go to, take coffee breaks and lunch breaks when I was supposed to and be involved in doing something that I was there to do and had to carry through with it and not sort of just give up.*

Although Ann did not complete the rehabilitation program, she capitalized on the momentum by looking for work. Her first job, lasting a year and a half, was an unskilled position in a dry cleaners, folding shirts and serving the public. With this work experience to her credit she moved on to a job as policy typist for an insurance firm, a job that tapped into her clerical skills. Ann held this job for approximately a year before moving on to her present position.

The second major turning point for Ann occurred with her first episode of schizophrenic psychosis in the third year of employment in her current job. Ann did not consistently comply with the prescribed anti-psychotic medications because of the side effects from the drugs, specifically weight gain. After a year and half of recurring psychosis and psychiatric hospitalizations, Ann received a letter from her employer stating that she would be terminated from her job if she did not take her medications as prescribed. Ann was angered by the letter, in

particular because similar strategies were not used with employees who had taken excessive time off with non-psychiatric medical conditions. She recognizes that today the letter would not be considered a legal practice, but believes that it initiated a change in her behaviours that promoted her ongoing work stability:

> *A: Well, at first I was furious and angry that they had done such a thing because I could see people that were taking three months off for gallbladder operations and I felt ...*
> *T: It seemed unfair.*
> *A: It seemed unfair. But actually in the long run it did help me to keep my job and to keep on my medication. And then I learned to cope with it, just by dieting and that type of thing so even though, so that worked out for the best in the long run.*

Case Analysis

1. Work recovery is best understood from a life course perspective.

If the well known predictors of employability for persons with mental disorder, specifically a good pre-morbid work history and a later onset of disorder, are applied to Ann she appears to be at high risk for poor work functioning. Taking a life course perspective allows for the examination of the relative influence of, and the interaction between, several individual and environmental factors that contributed to the evolution of Ann's vocational development.

Ann's early development instilled in her the importance of self-sufficiency and the values of her Christian faith. These values appear to have remained relatively dormant during the period of Ann's early hospitalizations and immersion into the role of mental patient. Yet, in response to a particularly severe suicide attempt, Ann became open to considering the potential inherent within these values and called upon them to serve as the cornerstone for the development of hope and an active stance towards her situation. Specifically her faith gave meaning to her suffering by defining her efforts to overcome life's challenges as the path to salvation.

The life course perspective demonstrates the dynamic nature of Ann's mental disorder and its impact on her involvement in work related activities. While Ann's first diagnosed episode of schizophrenia presented at the relatively late age of twenty-nine, her history provides evidence of psychotic-like experiences during childhood. These were followed by a rise in depressive symptoms in adolescence that culminated in multiple psychiatric hospitalizations and therapies. In spite of these early mental health symptoms Ann managed to maintain her involvement in functional activities, sometimes marginally as in her academic and social performance, and sometimes excelling as in her involvement with school athletics. Even at the lowest points of her mental health and in the most constrained environment of the institution, Ann pursued involvement in purposeful activity:

> *A: It was just in occupational therapy. I liked to go to that while I was in the hospital. I'd get up in the morning and go and do something. I didn't like to stay in my bedroom doing nothing, so it was awful at the time. And I liked to go down to the occupational therapy and do things. And in the woodworking shop I made a couple of bookends and a little treasure box and that type of thing. I enjoyed doing that.*

Reports from mental health professionals suggest that Ann's adolescent bouts of depression were likely early presentations of schizophrenia. This would provide an explanation for her poor response to psychiatric therapies at the time and her good response to neuroleptic medications at the onset of the psychotic symptoms. Regardless, throughout the course of her mental disorder, Ann gained proficiency in managing coping strategies in relation to work related problems and transferred this learning to new situations and challenges. Ann views her accomplishments within the work realm as a process of gradual but continuous growth and development:

> *A: Well I think I've grown since then. I think I've had the opportunity of each different phase of going through things that I've learned to speak to people in a normal way and accept things in a more normal way. Because like each thing is like a hurdle and once you get over*

one hurdle, it gives you the strength to go on and do the next, go over the next. Do you know what I mean?

Although she has maintained the same work for twenty years, her job has grown in complexity and in responsibility. Initially hired as a file clerk, Ann progressed to positions as a microfilm clerk, a checker and finally the sole clerical float. Ann's progress was impacted by a variety of challenges, some of which required the management of impairments associated within the mental disorder and some of which required negotiating the broader social context of work. She also benefited from the ongoing job changes that occurred across her career trajectory. As she remained stable in the workforce she developed skills and abilities that facilitated her progress to more responsible jobs. By the time she experienced her first psychotic episode she had several years in the workforce and had moved in to a job within a well developed organizational structure that provided some worker protection through employee related policies, benefits, and employee assistance programs. Similarly, over the course of time Ann was able to benefit from the changes that naturally occur within a work place. For example, although Ann's growth within the job was reinforced by her general sense of acceptance by coworkers, she also experienced specific incidents of rejection that she perceived to be related to her mental disorder. This problem was often resolved naturally, over time, as individual colleagues who viewed her unfavourably, moved on to other positions.

> *A: And then, but I was a microfilm clerk at the time and a checker position became available and I went to apply for it and I had an interview with the Assistant Director who had become Director. And she said to me, "Ann what would you like to be once you become a checker if you got the job?" I said, "I'd like to work on the complete chart with the doctors, help them clear their charts". And she said, "My don't you reach high over your head?" and she didn't give me the job. But the Director that took over from her years later gave me the opportunity to learn checking and it's worked out fine.*

Ann's case history illustrates how broader environmental level changes were instrumental factors in the process of her work recovery. She believes, for example, that the development of more community oriented rehabilitation services, such as those available today, would have facilitated her efforts at work integration at an earlier point in time:

> *A: I think they have come along now, since back then. Like the schizophrenia program here, I think at that time, like if I had of had what they offer here at that time, I wouldn't have probably gone through as much as I did.*

As it was, she spent many years in and out of hospital with little direct assistance with community integration.

Ann has also witnessed a change in the social perceptions of the vocational possibilities for persons with mental disorder. Once thwarted from pursuing her vocational goal of nursing assistant because of her experiences with mental disorder, Ann was recently approved for retraining as a patient care assistant as part of an employee training effort to minimize the downsizing effects of the restructuring of her department. Although Ann decided to continue with her position in Health Records, this approval to follow a career path that she considers highly responsible provided her with validation of her competence and her ability to be self-determining.

Finally, Ann's active coping stance appears to have been enabled in response to changes in the medical understanding of her mental disorder. For Ann the growing acceptance that schizophrenia is a biogenic disorder countered the earlier messages that her mental disorder represented a psychological trait, a flaw of her personality. This medical view presented her with a personally palatable interpretation: she is "*just a person with an illness*" and not a person who is an illness. It also facilitated her open, albeit discrete, disclosure on the job by providing a

normalized explanation for her problems (i.e. an illness just like a physical illness) and the familiarity and predictability of a chronic condition contained by medications.

2. Positive meanings attached to the worker role facilitate the individual's ability to negotiate the stresses associated with the worker role.

When asked to quantify the importance of work Ann responded with a rating of eight out of a possible ten points. Despite the considerable problems and stresses that she has experienced on the job Ann only describes the meaning of work in positive terms, identifying the many benefits that it provides. She gives it less then a perfect rating to highlight that she has been unable to achieve a balanced lifestyle that includes a social identity away from the job. The rating represents her dissatisfaction with the extent to which her life is defined by her job rather than her dissatisfaction with work itself.

The analysis of the case study data reveal the following three distinct categories of personal advantage experienced by Ann through her work:

i) Self-sufficiency

Ann's job has provided her with the ability to meet the very practical realities of paying for her basic needs of daily living such as shelter, food, and clothing. Although she experiences her income level as constraining she does have some disposable income available to purchase items for her crafts and hobbies, to enjoy a weekly meal in a restaurant with her mother and for gifts for family members. The benefits package offered through her employment affords her a measure of financial security for the future in the form of a long term disability pension and a retirement pension plan. In addition, the benefits package provides an advantage with respect to her psychiatric treatment by giving her access to the newer, and most expensive anti-psychotic medications:

A: My medication is completely covered except for a $10.00 fee each year. But my Zyprexa now a month costs $340.00 and the drug plan pays for that. My doctor I think told me, like if I quit this, let's say I had to leave the hospital and got another job that didn't have a drug plan, of course I wouldn't be able to afford the Zyrexa because I probably would get a job that only paid $10.00 an hour or something like that.

This financial situation is intrinsically rewarding for Ann. She experiences a sense of pride and achievement through the fulfillment of her family values of self-sufficiency. It also provides her with the opportunity to contribute, reciprocally, to the financial well being of her parents and siblings and thus to experience the fulfillment of her strong sense of obligation and commitment to her family :

A: And I'm able to walk to work. I sold my car, but I still have my mother's car that I can use, because it's too expensive to try and keep two cars because my dad's pension money was all going into keeping him in the nursing home. So my mom, so I'm sharing the rent with her now, so that's another big change for me. I used to always pay room and board but now it's even more responsible.

For Ann, this self-sufficiency is further evidence of her successful recovery from the identity of mental patient. The possibility of registering Ann for a disability pension was considered both during her period of institutionalization and the first episodes of the schizophrenic illness. She believes that the acceptance of these disability benefits would have represented a final descent into the total identity of a mental patient (A: "*You know I would probably just waste away*").

Ann's psychiatrist highlighted the importance of Ann's mental attitude towards self-sufficiency. This mental attitude reflects a strong sense of commitment and obligation towards her family who have supported her and accommodated her needs without a false sense of entitlement. He stated that this attitude represents a ... "*balance between not being too grateful for any crumb that gets thrown her way and not too owed or entitled*".

ii) Self-worth and self-esteem

Participation in employment contributes to Ann's positive sense of self-worth and self-esteem. The fact that she has experienced acceptance in a real employment setting provides her with the ongoing evidence that she is a worthy individual and valued employee. This enables her to distance herself more and more from the identity of mental patient. She has proof of her value within the work setting but she also recognizes that her skills and experiences can be generalized to other employment situations.

Her development within the workplace has particular significance for Anne, since she has not achieved a similar level of development in social arenas outside of the work context. This evidence has taken three forms. First, through employment Ann has witnessed the consolidation of specific task and social work related skills. Ann has progressed to the key position of knowing all of the related jobs in her department, a position that has included the responsibility and status associated with teaching coworkers. This has enabled her to maintain, simultaneously, a sense of commitment to the workplace and a sense of autonomy and personal agency that does not depend on the good intentions of the employer. For example, Ann is troubled by the full scale reorganization occurring within health records but is secure in the expectation that she will be employed regardless of the job changes within her own department:

> *A: But I just try to take it day by day and whatever happens I'll find something somewhere. It's going to be hard, I know, but I'll get through it.*

Second, her interpersonal contacts on the job, have enabled Ann to develop a normalized perspective on her own situation that contributes to her sense of self-worth. The comparison is even more favourable given that Ann considers her social difficulties to be largely the result of an illness, while she believes that many of her coworker's problems are of their own making:

> *A: That's right, with meeting people, like some of the people at work, I think, gee, I'm not so bad after all.*

T: What do you see now when you look at other people? Like what kinds of things do you see that strike you as being bad?
A: Oh to do with their lifestyle and that. I would never live like that and they get themselves into trouble because of the way they live. and I just think gee. I mean I have schizophrenia and I wouldn't even act like that.

Finally, by virtue of her successful participation in work. Ann has achieved a special status within the mental health system. On several occasions she has addressed groups for parents with children with schizophrenia. In telling them her life story she hopes to encourage the sense of hope they will need to see their sons and daughters through the process of recovery. In addition to the psychological benefits of altruism the experience reaffirms her sense of normalcy. In an almost paradoxical manner, it publicly recognizes her as an individual with schizophrenia while simultaneously distancing her from the identity associated with mental patient.

iii) A context for coping

The process of developing an acceptable social identity. beyond the identity of the mental patient. required Ann to participate in the broader community. Opportunities to become involved in work environments were presented to her early in her process of recovery. Ann experienced both success and personal satisfaction in her early work related efforts and subsequently continued to direct her recovery efforts within the realm of work.

The case study presents information about several challenges Ann has faced in managing work. These include challenges associated with learning new tasks, performing at acceptable speed on the job while maintaining standards for quality, keeping the symptoms of the illness and side effects of medications in check, and interacting with coworkers and supervisors. Ann describes these challenges as "*hurdles*" to be overcome in the process of her growth and development as a worker. While they pose a risk of failure and subsequent feelings of being

overwhelmed and depressed. Ann does not routinely experience them as harmful to her mental health and emotional well being. She has a general sense of confidence about her ability to control these challenges and a balanced perspective on the threat that they pose.

Work stress that she does experience as personally deleterious includes those interpersonal situations where she perceives that hostility or critical evaluation. Ann has less confidence in her ability to manage these stresses and considers them particularly threatening. While her default approach is to maintain a passive social detachment she also looks to external sources of support to neutralize her perception of their threat and for assistance with the development of strategies to actively deal with the situation.

It is important to consider that prior to her first hospitalizations Ann had entertained the likelihood that her future would include marriage and a family (A: "*I used to say when I get married I won't have to work*"). While this future was not realized Ann understands that her involvement in work rather than family represents a more personally suitable context for coping. She describes the stresses associated with the role of mother as beyond her own coping capabilities:

> *A: You know I've had this fear of passing it on to my children. I think I might be able to cope with a marriage but I don't think I could cope with the raising of children. That's a big responsibility. I think that's one of my limitations that I feel I don't think I could do. Do you know what I mean? That is one area I think I know, because with my sister's children I love them and I baby sit them, but I don't think I could be responsible on a day to day basis. I don't think I could. I think it would be too much.*

The content analysis of the meaning of work for Ann reveals several underlying themes. The principal, unifying theme is that participation in work is both the process and the outcome of her recovery from her engulfment in the role of mental patient. It represents both her health and her normality. Second, the advantages and challenges that Ann experiences within work are both

commonplace and specific to her own situation as an individual building an identity separate from mental illness. This is an empowering perspective that enables Ann to understand her own efforts in a normalized framework that gives credence to the universal struggles associated with work. Third, the personal growth that she experiences within the job depends on the successful negotiation of challenges. The evidence of her health emerges from her ability to confront these hurdles. Fourth, those stresses that are associated with a direct negative effect on her illness are limited in scope to critical interpersonal interactions. However, even at low levels this stress can undermine her psychiatric stability. Fifth, the meanings associated with work have evolved in response to Ann's lengthy periods of stability and growth within the worker role. For example, her concerns as a worker have shifted from a primarily here and now approach to anticipating and planning for the future, and from a concern for self-sufficiency to a growing responsibility for the financial well-being of her family. Finally, the meanings she associates with employment in the community labour force have enabled Ann to resolve the loss of the highly valued roles of spouse and mother.

3. A central feature of work recovery is the individual's perception that it is possible to create functional self-identity separate from the disorder.

Ann's perception that it was possible to create a functional sense of self-identity was not only a central feature of her work recovery, it appears to have been a primary catalyst for the process. The picture of Ann as a young adult is consistent with that of an individual engulfed in the role of the mental patient. The factors that contributed to this loss of a healthy social identity included: longstanding and severe affective disturbances; longstanding social and academic marginalization; lengthy periods of institutionalization; the lack of access to community oriented mental health services; failure in response to her own efforts at reintegration; personalized

explanations for the source of her mental disorder, and; a lack of positive response to psychiatric therapies.

Ann herself refers to this as a dark period of her life, when she learned *"to be a mental patient"*, that she *"wasn't really a part of society"*, and culminating in feeling like a *"freak"*. It is noteworthy that although Ann believes that she has largely overcome this internalized stigma, she continues to feel the repercussions of the experience. She states that the limited social opportunities *"stunted my growth"* at the critical developmental period of the adolescent/adult transition and subsequently affected her opportunities to meet people and develop social skills. Although she is content with her work and family life, Ann believes that this thwarted social development interfered with the possibility of marriage:

> *A: I think it would have been nice to have been married but it didn't happen and I'm forty-six now, you know I don't feel a loss there, I don't feel sorry for myself. It didn't happen because I was so very, very ill all those important years that at least I'm out of that severe suicide attempt at least. You know they had to bring me back? ...Yeah, I think that maybe that did stunt my growth at that time. That I wasn't able to learn the skills of growing up in that way. It damaged that part of me, maybe it did. I think probably when I look it did.*

In Ann's case the beginning of work recovery is clearly demarcated by a specific event, a crisis. Although she had several previous suicide attempts, her final attempt brought her so close to death that it frightened her into taking action:

> *A: The last time I tried it I was twenty three and it's just by the grace of God that I'm here today. I feel that he's given me a second chance and I was in a coma and the doctor said he couldn't really feel a pulse or respiration on me at one point, but I came through it. And from there that was a turning point. After that I really started working on it.*

While this event initiated a major behavioural change to an active stance towards her mental health and well being, it does not provide an understanding of why or how Ann's efforts became so firmly directed towards employment as the route for this change. The case study reveals the following phenomenon that contributed to the definition of Anne's work recovery in these early

stages: i) identifying with Christianity; ii) the introduction of a work ordered day; iii) valuing self-sufficiency : and iv) conceptualizing limitations within a growth framework. While these aspects are discussed individually. they are actually highly interrelated. In this case study they appear to have been occurring simultaneously. although the relative importance of any one aspect would change in response to the specific context. Furthermore. each of these aspects could not be considered uncharacteristic of Ann prior to this turning point. Rather. they can be understood as strengths that were evident well before the first hospitalization. but remained untapped during the period of engulfment in the patient role.

i) Identification with Christianity

In response to the final suicide attempt Anne became open to understanding her problems within the doctrines of Christianity. an option that had been introduced to her by family members and her physician. By giving meaning to her distress. Christianity provided Ann with hope and the obligation of rising above hardships:

> *A: Just a way of salvation and no matter how much I have to suffer. I'm suffering for the Lord and just try. and my life was not mine to take. And just that simple thought that I have to go through whatever I have to go through in order just to bear up. do you know what I mean?*

Unlike the medical interpretations of her condition. Christianity did not hold her responsible for her illness, but it did hold her responsible for the manner in which she chose to live with her illness. In addition Christianity provided Ann with principles and guidelines for action on the job. particularly troublesome social situations.

ii) The introduction of a work ordered day

Ann's introduction to a community based vocational rehabilitation services occurred three years after her initial hospitalization. She recalls this as her first opportunity within the mental

health system to address issues related to community adjustment. The services gave her a structured routine that she had been missing during her years in institutions and this structure was directed to preparing her for work. By reestablishing the routines of a work ordered day, and providing simple and manageable work tasks, the services provided Ann with responsibilities and expectations that required manageable coping efforts within the work realm.

iii) Valuing self-sufficiency

Ann recalls that, from her teenage years, her family did not press her to meet high achievement standards, but they did impress upon her the importance of self-sufficiency. While Ann had established a career goal of nursing assistant she also considered the possibility that she could, like her mother, establish her work and financial independence within the context of the marital role. In response to her psychiatric illness and functional decline the importance of self-sufficiency became accentuated (A: "*I think it was my parents you know, trying to instill in me that one day I'm going to have to look after myself. That they weren't always going to be there.*"). This was supported by her physician who refused recommendations to place her on disability benefits while directing his efforts to find and maintain real employment opportunities for Ann. Financial considerations were a motivating factor in Ann's move from the rehabilitation service to competitive employment and her subsequent efforts to upgrade vocationally:

> *A: Anyways, after the dry cleaners, I thought maybe I could start working in an office.*
> *T: Start working in an office?*
> *A: Getting a job that paid a little bit more because I knew that I couldn't live, you know, on the salary that I was making at the dry-cleaners.*
> *T: It was a part-time job?*
> *A: No, it was full-time, but at minimum wage and I thought maybe I could start to better myself.*

iv) Conceptualizing limitations within a growth framework

Ann's approach to work was cautious and methodical, searching for employment opportunities that would "*click*" with her abilities. Although Ann had a sense of her competencies and limitations, her understanding of these actually developed in response to trying out different work options. Approaching work from this perspective allowed Ann to view her frequent job changes in a positive light, as a learning experience, rather than a failure:

> *A: I had tried a number of different jobs. Like they'd hire me and I'd quit after the day. I'd get this overwhelming feeling that I'm not going to be able to do it and I'd quit. And my parents would have a fit because I kept doing this and I told them, mom and dad, one will click, one will click, and then I got the one at the dry cleaners and I stayed there for about a year and a half.*

Apparently untroubled by the relative lack of social status imparted on these jobs, Ann maintained pride in her work:

> *A: Oh yes. I'm very conscientious about how I do my work, even though some of them weren't important. Like to maybe other people it was just a joe-job, but I made sure I did it properly.*

She selected jobs that challenged her task and social abilities within simple and repetitive work routines. Ann moved on to new challenges once her appraisal of her skills and confidence suggested readiness for a new job and new hurdles.

Ann's adolescent work related experiences provided her with a foundation for this growth perspective. In her high school years Ann's work aspirations were developed in relation to the need to be self-sufficient rather than to meet high achievement standards. She was familiar with adjusting her vocational direction and learning expectations in relation to her abilities. Finally, she had considerable experience with the struggles inherent in managing work related demands in the face of significant mental health problems.

The advent of her first psychotic episode at the age of twenty-nine represented a significant threat to Ann's development as a competent worker. The event reintroduced periods of psychiatric hospitalization, disrupted her relations with coworkers and threatened her job tenure, bringing her dangerously close to the dependence and occupational void of disability benefits. The case study suggests that these events did not progress because of two important factors: Anne's positive response to anti-psychotic medications and the extent to which she had already consolidated her competence in the worker role.

Ann credits neuroleptic medications with bringing the symptoms of schizophrenia under control. The onset of schizophrenia directed Ann's attention to keeping on top of psychosis, and when she speaks of "*getting help*" for "*breakthrough symptoms*" she is speaking first and foremost of medications:

> *A: Yeah, and nothing would have gotten me out of that except the medication. My symptoms are severe even though I have to be on medication, I can't come off it. I may appear like I don't get that sick but I do.*

The medications do not directly assist her on the job, but rather they maintain her mental stability within a level that allows her to cope in the realm of competitive employment.

By the time the psychosis appeared Ann had established herself as a competent and valued worker through six years of competitive employment. While the symptoms and impairments of psychosis presented a threat to Ann's ability to function in the workplace the case study suggests that she took them in stride as another set of challenges or hurdles to overcome. Ann had the opportunity to take this approach because over the course of her work recovery she secured employment in a workplace that provided her both with formal standards for protection of job tenure and clarity about the ultimate expectations for her performance on

the job. The employer afforded Ann time off from work to recover from the acute episodes of schizophrenia while providing explicit expectations regarding her behaviour on the job.

It is interesting to note that although these psychotic episodes presented a setback in the process of Ann's work recovery, Ann states that the experience made a unique contribution to the development of her self-concept as a worker. Ann placed considerable personal significance on the fact that her coworkers continued to accept her after they witnessed her bizarre behaviour. Their acceptance represented the absolute evidence that she was "*just a person with an illness*":

> *A: I just took things a little step at a time, sort of thing, you know. Gradually built up my confidence and like I say after I worked at health records when I got really ill there and then after that the people still treated me like before I became sick. And that was... I didn't feel like a freak anymore. That was a big turning point too.*

4. **Internal locus of control, self-esteem and commitment are psychological factors associated with work recovery.**

Of central importance to Ann's work recovery was the resolution of control issues related to the illness. Initially, a major suicide attempt served as a catalyst for the development of a stance that simultaneously allowed her to accept that she had a mental illness but ultimately she had control over the direction and outcome of her life. This was a critical incident that marked her transition from being a mental patient to an active strategist and participant in her recovery. While the recognition that she had come close to death may have initiated this transition, Ann turned to religious faith to support and guide her in the process of gaining control over her life. It is noteworthy that Ann did not continue with her family's religion. Rather she intentionally selected an organized religion with a structure that maintained her faith by providing her direct access to the doctrines of Christianity:

A: Yes, and I think that's built my faith as well because people that have things in front of them, like the Catholics have a lot of material things like the statues and all this type of thing, it's so false. That sort of when something tragic comes along that their faith doesn't hold up because it's the material things they were clinging to rather than spiritually.

Ann directed her recovery efforts towards employment but selected her jobs based on her understanding of her strengths and limitations. That is, her efforts appear to have been less about learning to adjust to the illness and more about achieving success at work by acting in a manner that was consistent with her abilities and resources. This understanding of personal strengths and limitations included an appreciation of her own skills (A: "*...those little things helped me grow a little bit and I was taught to be able to speak to the public*"), and people and material resources (A: "*I was staying with my aunt a little bit at one point thinking that might help, getting away from my parents*"), the social stigma of mental illness and her own internalization of this stigma. This process of personal understanding and adjustment was actually facilitated by the changing medical interpretation of her illness that enabled her to conceptualize herself as a person with capacities to be realized, rather than as the source of her own problems.

The appearance of psychotic symptoms presented Ann with a new set of personal characteristics to integrate within the context of her ongoing experience with work recovery. Although she could not control the reality that psychosis was now part of her life, Ann recognized that medications could control the psychosis and her desire to maintain work superceded her dislike of the medications. Beyond the very basic resolution of the acceptance of medication, Ann's work orientation influenced her development as an active strategist relative to the psychosis and the medication. Thus, she became proficient at checking for the signs and symptoms of illness, compensating for the weight gain that was a side effect of the

medication, targeting medications to control specific symptoms, and working closely with her psychiatrist to find the most effective type and dose of medication.

From the beginning of her recovery Ann directed her work activities to ensure success experiences that would facilitate the development of her self-confidence and self-esteem (*A: "I didn't take on anything more than I thought I could handle"*) and terminated work related activities when she perceived a significant likelihood of failure (*A: "I just feel like I want to get out of there if I can't do it, I want to get out of it, just not continue with it"*). She found that participation in work related activities exhorted her to further action by building her self-confidence (*A: "And then gradually it builds your confidence and then you feel that you want to do more things"*). Although the signs and symptoms of her illness are largely under her control, they continue to undermine her confidence by impacting on her job performance and affecting her ability to accurately interpret social situations.

It was primarily the work context that provided Ann with opportunities that she perceived as confidence building. Ann considered work expectations to be more manageable then those associated with intimacy and motherhood (*Note from the medical chart: "Ann perceives a high level of stress on the job and is pleased that she is able to cope. She says that she discovered that personal stress is more stressful to her than work stress."*) because they were largely task oriented, had structured times and activities with limited responsibilities, allowed for simultaneous social interaction and social distance and were less emotionally demanding.

Ann describes her experiences with the demands of work within a growth framework. She refers to challenges as "*hurdles*" to "*get over*" in order to get the "*strength to go on and do the next*". She understands her growth as a developmental process that is characterized by a few major turning points but largely progresses "*a step at a time*". Over the course of time and work

related experience, managing most challenges has become an automatic routine, requiring little conscious thinking or strategizing (*A: "But I've lived with it for so long I've learned to adjust, cope and live with it"*).

The case study of Ann reveals an interesting picture of a soft-spoken and mild mannered woman who demonstrates a quiet determination and tenacity within the realm of work. This is a picture that is consistent with those characteristics that are associated with active coping including internal locus of control, self-esteem and a challenge orientation to stress provoking situations. This study of Ann suggests that these are dynamic characteristics and that their development is an inherent aspect of the changes that underlie work recovery. That is, these psychological factors are best understood as both integral aspects of the process and the outcome of work recovery

5. The individual's perception that valued people believe in his/her potential is associated with work recovery.

The case study data highlights the importance that valued people have played in supporting Ann's work recovery. These people come from the two sectors that are the most prominent in her social network: her family, and mental health professionals. Although Ann's social network is dominated by relatively few sectors, these reflect largely separate clusters of social relationships. That is, there is little or no interpersonal contact across clusters and they represent relatively distinct sources of support for her many work related needs.

The two most important sources of work related support have been her parents and mental health professionals. A common underlying dimension of support offered by these two sectors is Ann's perception that these valued people maintained a genuine and consistent belief in her worth and value (*A: "I think my parents...the support...my parents have always supported me*

and they never gave up on me on my lowest times, even when I was suicidal"). Ann's realization that these significant people in her life believed in her potential was a catalyst for Ann to begin to have hope for herself and to begin taking the first steps on behalf of her own recovery. This belief was demonstrated to Ann in many different ways and the mode of transmission appears to have influenced the processes underlying work recovery.

Ann's parents supported her work recovery by being explicit with respect to their expectations of her, while providing a great deal of latitude in the process of her growth and development. They instilled in her the necessity to become self-sufficient without imparting expectations related to status and achievement:

> *T: Was there a high emphasis in your family on school?*
> *A: No, my parents never pushed that. In fact my parents were the first ones to say to me after...I was 18 when I left hospital and trying get a job, my parents were just concerned, even if I worked in a factory it would be O.K. with them.*

Ann experienced her parents as encouraging her to try work and as responding positively to her efforts while exhibiting a high tolerance for failure:

> *A: It's important not to give up and say well I don't know what to do now? Just say maybe something will click. My parents didn't get mad at me they just said, okay, well keep looking , keep looking for a job and not saying I'm going to kick you out of the house if you don't get a job.*

Ann's parents also supported her work related efforts by providing her with physical resources, such as room and board and a car. While this practical assistance enabled the process of work recovery by directly promoting adaptation to job related demands, it also appears to have indirectly influenced the process by: strengthening Ann's perception that her family believed in her potential and subsequently provided further reinforcement for her efforts; facilitating self-sufficiency through the expectation that she would pay them back for the resources within a manageable reimbursement schedule (*A: "I had to pay my father back for the car, that second-*

hand car that he had bought me. I had to pay $10.00 a week in room and board.") and: instilling a sense of obligation and commitment towards the family that motivates her to maintain a level of mental health that is consistent with employment in order to fulfill her responsibilities:

> *A: Well, there's been such a lot with my mom and dad and I, this past little while, I've been busy trying to be a support for my mother because she cries quite a bit you know and she feels guilty about putting my father in a nursing home and that. So, I'm her support now and I have to make sure that I stay well enough to be able to handle that.*

Within the mental health arena Ann's physicians had the most prevalent influence on her work recovery. Ann perceived the refusals to qualify her for a disability pension as an indication of their belief in her potential (*A: "... because the doctor knew, he felt I could do certain things*") and as active efforts to prevent her descent into the passive and hopeless role of a mental patient. The fact that authoritative professionals advocated against a disability pension on her behalf was particularly critical at those two instances. (i.e. early institutionalization and her first psychotic break) when some sign of hope was required to counterbalance the serious erosion of faith in the belief that she would regain psychiatric stability:

> *A: But that's when the doctor had to step in and he told them as long as I learned to take my medication I would be all right because they told him they wanted to put me on a disability pension and he said no that's not a good idea, they would ruin my life if they did that.*

Her understanding that her psychiatrists' approach to the pension issue was unconventional enhanced her sense of self worth by highlighting the extent to which there actions represented genuine caring and hope.

Ann's physicians were non-traditional in their support both in their focus on maintaining her in a worker role and in the strategies used to promote her well being. For example, in response to Ann's severe depression, suicidality and the inability of psychiatric treatments to provide any significant relief, her physician offered her religion as a means to find the meaning and direction

she required to become a participant in her own recovery. He encouraged her to maintain her belief in God's acceptance and support and used the doctrines of her faith to learn approaches to deal with difficult work situations (A: "*He told me scripture, where those things were found in the word of God, you know the Bible.*"). He also acted in an affirmative manner to get her a job directly within his own work sphere (A: "*...and he went to the Director of Health Records and asked them if they would interview me for a position there, which they did and I got the job through my family doctor*").

Mental health professionals represent Ann's only source of support for directly addressing the issues that relate to the interaction between the worker role and her psychiatric illness:

> *A: I continued to come here for a sounding board you know because...well my dad can't right now anyways but my mom too, even though they've given me lots of support with these things, they don't know how to just, like without being frightened that I'm going to get sick or something. Like let's say I hallucinated or something like that well coming to the occupational therapist I know I can talk to her about that.*

This support has taken several forms including: i) frequent meetings to monitor and stabilize the mental disorder so it does not impact on the worker role (A's psychiatrist: "*I don't want her off work for long, only as needed, so not to destroy work's faith in her functionality.*"); ii) counseling to distinguish between work experiences that are illness related and those that are a normal part of the work environment; iii) counseling to assist her with the development of strategies that facilitate performance in the worker role; iv) collaborating with the employer to establish reasonable accommodations to enable Ann's successful job performance, and; v) focusing on her skills and abilities within the work context (A's psychiatrist: "*I told her, 'You are perfectly qualified' and she got through it and was proud*").

6. **An integral feature of work recovery is the individual's appraisal of employment as essential to mental health and well-being.**

Ann views her participation in work as essential to her mental health and well-being. She stresses, however, that schizophrenia, is a distinct phenomenon, and that she would continue to be vulnerable to the signs and symptoms of the mental disorder regardless of her employment status *(A: "Because the illness is the thing...like when it's not controlled by the medication, the illness will show itself not matter what, work or no work").*

The case study data suggest that employment positively influences the course of Ann's mental disorder in two ways. First, in an attempt to maintain her successful participation in work Ann is vigilant about monitoring the status of her mental illness, following her medication regimen, and fine tuning her medication treatment. Sensitive to the fact that her mental status can rapidly deteriorate and that she is unable to manage employment while in an episode of acute psychosis. Ann works closely with her psychiatrist to control the illness in a manner that will protect her employability.

Second, Ann's work provides her with a reason to develop active strategies to manage the ongoing signs and symptoms of the mental disorder *(A: "Generally speaking, yeah, I think it can help people be able to cope and work with their illness").* So while Ann experiences hallucinations on a daily basis, she manages them actively within the context of work:

> *A: I don't let it interfere with my day-to-day work. Like I hallucinate still. This other person I knew he had a job, a contract job, and he would go to the sick room and lie down.*
> *T: He withdrew?*
> *A: Yeah. Why are you doing that? You don't need to do that. Because you just accept that that's part of the illness and go on and go on and like he was babying himself. I don't like, I mean I'm healthy and he was ...he was babying himself too much. I mean some people go overboard.*

The case study data suggests that the concept of "coping" does not adequately reflect the meaning of these efforts. While coping implies a process of dealing with and overcoming problems, Ann's work related efforts have the broader meaning of a growth experience that

confirms her identity as a healthy individual. Ann's participation in employment has inherent risks. Given that her job is highly personally meaningful. it leaves Ann vulnerable to the threats to self-worth and self-esteem that are inherent in failure experiences. These failure experiences provoke feelings of despair and depression and undermine her attempts to distance herself from the identity of mental patient. Similarly. these risks leave open the possibility of experiencing the psychological benefits associated with success experiences. Ann describes the outcomes of successfully negotiating work related demands as a sense of normality. personal growth and fulfillment. social validation and acceptance.

Summary

This chapter presented the description and analysis of the case study of Ann who has been employed for twenty years as a clerical worker in the medical records department of a large general hospital. Consistent with the theoretical propositions of work recovery, the life course perpsective demonstrates the central role that work has played throughout her adult life. From Ann's involvement in purposeful activities in the psychiatric institution to her present job as clerical float. her work life can be characterized as a career trajectory with subtle but consistent progress in work accomplishments and responsibilities.

Ann's relationship to community based work was severed by longstanding institutionalization related to psychiatric disorder. Her initiation into work represented the outcome of a significant shift in her understanding of herself with respect to the illness experience. Through the awakening of a profound religious faith she came to believe that she held the power overcome her engulfment in despair and hopelessness and also the responsibility to meet life's challenges.

Work provided the direction for her recovery and engaged her in efforts to manage the illness within the employment context. While her rapid progression from psychiatric in-patient to employee represents a startling improvement in psychosocial status. the theoretical propositions inadequately address the extent to which the process of work recovery involved the ongoing negotiation of the work-illness interaction.

While she came to view psychiatric medications as a cornerstone of her ability to function on the job. the experience of schizophrenia permeated her struggles to adapt to work. Her sustained interest in work involvement was facilitated by her perspective that work related struggles represent growth and development. and that difficulties within the work environment are universal. In addition she developed specific strategies to identify and manage the symptoms of psychosis within the work environment.

Consistent with the theoretical propositions. work held significant personal meaning for Ann as the enactment of a functional and moral self. Work became a vehicle for the development of her role within her family. It provided her with the opportunity to engage in valued and meaningful roles within her family social network as an outcome of their shared value system and her growing financial stability. Work also served as her primary means of broader community integration and compensated for the loss of her expected roles of wife and mother. Ann understands work as central to her healthy functional identity and considers the loss of work involvement as a path to engulfment in despair.

Ann's social network facilitated her work recovery by believing in her potential for work recovery. They conveyed this belief by providing her with real expectations and obligations while simultaneously offering her practical and emotional support. Professionals have been helpful by assisting her with the struggles associated with maintaining work and creating real

work opportunities. Perhaps most important, by engaging her belief in God they facilitated her development of a divine source of acceptance and support and a doctrine for living that espoused the value of work.

CHAPTER 5

CASE STUDY 3: GEORGE

Case Description

Filling up the days

George hasn't been employed in a regular job for seven years, since he left his part-time position as an activation coordinator on a hospital psychogeriatric ward. To deal with the relative inactivity of unemployment George is careful to impose a regular routine of activities in his life. George's schedule of activities include visits to a psychiatric day centre two afternoons a week to participate in a social-leisure group and to apply his writing skills editing the centre's newsletter. He recently completed "Living with Schizophrenia", a psychoeducation group that provided information about the illness, medications and new approaches. To fill in the days George goes on community excursions such as visits to libraries, long walks, or meeting with friends to chat over a coffee or to watch a video.

The experience of unemployment disturbs the distinction between weekdays and weekends extending George's need to organize activities:

> *George (G): ...before when I was working and I was healthy, the weekend was the fun time, I looked forward to the weekends, but now my weekends are like everyday, another day to get through.*

On the weekend he attends church services in the evening and socializes with a few of the parishioners. He extends this involvement with the church to volunteer for their Sunday night, winter program providing the homeless with meals and a place to stay.

An erratic schedule leaves George vulnerable to disruptions in his sleep cycle. He prefers to sleep until mid-morning to shorten the day and to save money by eating his lunch at home. Sleeping too late in the morning, however, compromises George's ability to fall asleep at night

and can lead to excessive caffeine intake and late night wandering. This is a pattern that can provoke the hyperactivity and the suspiciousness that are symptoms associated with his mental illness:

> *G: To be honest with you sometimes I, you know, sleep in you know till two or three in the afternoon and I get up, I feel really crummy. You know half the day is gone already and I'm sort of struggling at okay, what am I going to do now to fill up the day? I don't want to go back to bed again because if I sleep all during the day, I'm going to be up all night and that's part of my illness that I have to deal with. It's part of the symptoms that happen so you have to be really careful to be out and active during the day and keep busy, so in the evening time it's sort of a winding down time. I cook my dinner, watch some TV and read a bit and it's a slow time and then I go to bed at 10:30 or 11:00 so it's more of a normal schedule. Rather, like when I get ill sometimes I sleep all day and I'm up during the night and I spend most of my time in the coffee shop or wandering around the streets and stuff.*

For the past six years George has received financial support in the form of disability benefits from the Canada Pension Plan and the Ontario Disability Support Program. The rent for his apartment in a public housing project is geared to his income. This financial arrangement provides George with a "*reasonable lifestyle*". He has supplemented his income with occasional "*under the table*" jobs. For example, through his participation in the day centre he has had paid speaking engagements at high schools or colleges to share his experiences of living with a mental disorder, and family contacts have also connected George with temporary physical labour:

> *G: Because sometimes, like my younger brother would learn of places that are hiring people on a part-time basis. I remember one time I worked for a department store for about three or four days and I made pretty good money because they were opening up a new store in a hurry and they wanted to get everything ready for the weekend opening.*

Vocational history

George attended high school in his native West Indies. Always a good student he was promoted to advanced level studies in languages. At sixteen his focus on academics waned as he

found the coursework difficult and was frustrated in his attempts to match his brother's academic achievements. The situation was made worse by his lack of vocational direction and his associations with the drug sub-culture at school:

> *G: No idea what I wanted to do for the future. Like some people plan to study the law, medicine or engineering but I was just sort of drifting through and I think that sort of exacerbated the situation and sort of made it worse because I was sort of drifting and sort of hanging out with the wrong crowd and they were bringing tokes into the classroom. We would go to the washroom and smoke up and then come and do the classes but it was really ineffective because you were so high on the drug that you were just happy. I wasn't really learning anything.*

George experienced his first acute episode of mental illness and his first psychiatric hospitalization in the context of what he describes as a "*feverish sort of drug induced state of mind*" that carried on beyond his control. He returned to complete his high school studies, an unpleasant experience that was marred by medication related fatigue, problems with concentration, poor grades and social alienation:

> *G: ...cuz when I went back to school some of them were making slag remarks and I could tell that they were laughing at me and making jokes about me but I just ignored them. But it was really difficult and I didn't feel comfortable going back to school.*

George describes his late adolescent years as largely non-productive (*G: "...after I graduated from highschool for two years I did nothing* ") and characterized by a lack of vocational direction, the decline of his basic self care (*G: ...my hygiene sort of deteriorated),* dependence on his parents and a lack of adherence to medication regimes that culminated in several psychiatric hospitalizations.

At the age of twenty George moved with several family members to Canada. The move was both the family's reaction to growing social and political unrest in the region and an effort to halt the decline in George's psychosocial status. This move demanded considerable social and financial adjustment on the part of his family and served as a catalyst for George's participation

in work. The first year he regularly accompanied his father to temporary employment agencies for unskilled, manual labour. In the second year one of these temporary employers hired them on full-time. George views this period of his work history as a particular achievement which resulted in a drastic improvement in his functional status and his social adaptation to a new culture, without the assistance of any psychiatric therapies:

> *G: It was amazing. I functioned well. The work was okay. Sometimes it was a bit tiring because it was mainly physical work, but I was fairly young and in fairly good shape then so I managed okay and I got along well with the other workers. It was a friendly hospitable environment in which I worked. And you know, I wasn't on medication at the time, not until after I had my breakdown in university, which was a couple of years along the line.*

After two years of working in these physical jobs George enrolled in a general arts program at university. He had an ill defined goal of preparing to "*work with people*", but university primarily represented a return to the vocational path he had expected prior to the advent of the illness:

> *G: It was sort of like a vague idea, just I knew I wanted to go to university. Because like most of my friends back in the West Indies were going into higher education whereas after I got sick and I was discharged I sort of spent two years practically doing nothing and so I wanted to make up for it you know.*

George's academic performance was poor, an outcome of his difficulty managing the high level of self imposed structure and self-direction required by university studies. He did, however, revel in the social opportunities that university presented, for example serving on a student council and moving into a campus residence. His social participation frequently included the use of drugs.

By third year of university the signs of his illness were slowly gaining prominence. He was "*behaving erratically*", "*getting isolated*" *and* "*staying up all night*". Fighting against psychiatric interpretations of the situation, George focused on the evidence that supported his

ability to function without medical treatments and evaluated his situation as representative of the typical life of a university student:

> *G: Part of me said maybe I should go see a doctor. or you know talk to somebody about it but I though I was just having a good time because at that time it was sort of like the norm for you know like campus life. people staying up late and sleeping during the day and partying.*

In response to the growing and intense fear associated with paranoia George sought help at a local psychiatric hospital and as an inpatient found security in the protected and structured environment. While George's interest in university continued several factors interfered with returning to his studies. He was self-conscious about the disclosure of the illness amongst his school friends. He had the sense that features of the university experience served as a catalyst for the reappearance of his symptoms. In addition his period of recuperation was particularly prolonged. His treatment at this time was characterized by several changes in psychiatric medications to stabilize the illness. There was a lack of assertive community oriented mental health resources and meaningful daily activities. He experienced a general sense of lethargy:

> *G: I remember there were some days that I would just sleep. I remember sometimes I would be up to have my dinner at 7:00 and to watch an episode of MASH. I remember it was really bizarre because the MASH episode was about a half an hour and I would eat my dinner watching it and then I would go straight to sleep. I'd take my medication and go straight to sleep. So it wasn't really a healthy lifestyle you know. I didn't really do much at the time.*

Six months following the acute episode George began to feel the need for more stimulation (*G: "...this is a good sign when you're bored at home you know."*). He entered a college based psychiatric rehabilitation program that used educational and social activities as a transition to academics or work. George found that regular involvement in the program of graded activities facilitated the amelioration of his problems with concentration, memory and medication related drowsiness (*G: "...it would get your brain working in a logical, coherent*

fashion"). His involvement with work placements through the program lead to part-time restaurant cashier work and he simultaneously pursued his personal interest in art by taking college night classes.

George's efforts to reestablish himself in work related activities were cut short by the exacerbation of his symptoms and a four month hospitalization. This marked the beginning of a three year period of relative inactivity. He continued to live in the family home and attend art classes but was largely immobilized by vocational indecision. The period culminated in another bout of symptoms and a lengthy hospitalization that incited George's psychiatric treatment team to attempt to reverse his inertia by directing him towards a rehabilitation oriented housing program:

> *G: Yeah, this was in 1984 when I turned 30. I think I came out of college, I had a relapse, I was in hospital for awhile and then there was a discussion among the group team members as to whether I should continue to live with my parents or should I move out into a group home. At first I was hesitant about it because Terry to admit, to tell the truth, I was sort of spoiled by my mom because she did the cooking the cleaning, the laundry. I didn't have to do anything at all. But going to the group home was an eye opener. I learned how to cook, I learned how to budget. I even learned how to do my laundry, budgeting skills, social skills you know. Plus they were around my age group, a little younger, but close to my age group and we had a good time. I enjoyed the company of the people.*

To cover the costs associated with this move towards independent living George was instated on disability benefits.

George describes his involvement in the housing program as a "*positive experience*" that not only prepared him for increasing levels of autonomy in community living but also provided him with a social network that reconnected him to employment:

> *G: Yes I learned a lot of things there, plus one of the befits of it was that, I remember the cook, it was summertime and I was sort of looking around for work to do and she said why don't you try that restaurant down by the water because her daughter worked there as a hostess and she made good money and she had a good time working there.*

George supplemented his income from the disability benefits by working part-time as a busboy for a large and popular restaurant. Although the pace was hectic and the routines were physically strenuous, George's performance was favourably appraised and he enjoyed the social atmosphere amongst the coworkers. He continued in this position as a regular part-time worker for two years and then as part-time summer help for an additional three. George's involvement in this position was also distinguished by his success at actively monitoring the relationship between work and his mental illness and employing coping strategies to maintain his mental health without disclosure on the job. For example, he found that he was prone to hyperactivity in response to sleep patterns that were disrupted by his late working hours. To manage the situation George would structure his days off to sleep longer and to decrease his level of stimulation.

Seeking activities with more intellectual stimulation and career potential, George pursued his interest in helping people and successfully completed, on a part-time basis, a community college diploma as an activation coordinator. He found college level studies to be a good match with his abilities. He benefited from the integration of academics with practical studies, the "*scaled down*" size of the campus and the classrooms and the clarity of structure and routines. George continued with his efforts to understand and control the illness. He had one three week psychiatric hospitalization but generally found that both his psychotic and affective symptoms were less intense and manageable.

Unable to find a job as an activation coordinator, George took related employment as a part-time homecare aide to gain the experience of working directly with seniors. The pay for the position was low and served only as a supplement to his disability pension. His satisfaction with the position was mixed. He valued the opportunity to apply his field of study and he was touched

by the richness of the life experiences of the seniors and their kindness towards him. He was frustrated by seniors with a *"crusty side"* and had difficulties maintaining emotional objectivity in the face of their distress and hardships:

> *G: But there are times even when I was working out in the community where I got too emotionally involved with the client and I was spending a lot of my free time there, even personal time that I wasn't being paid for.*

Tired of the physical and emotional demands of the job, George decreased his hours working with the elderly and returned to his former part-time job as a bus boy. He describes this move as *"troublesome"*. Although he formally reduced his hours he found himself over involved with the seniors and unable to terminate his community visits within the assigned work hours. In addition he was personally distressed and felt socially alienated by his lack of success in establishing romantic relationships with female coworkers at the restaurant. George believes that although he had never disclosed the mental illness, his coworkers at the restaurant could now detect peculiar behaviours. He was in fact simultaneously hospitalized for an increase in paranoia and hyperactivity as well as feelings of depression while maintaining employment.

Shortly after, George was employed in his last regular job as a part-time activation coordinator on a geriatric unit in psychiatric hospital. He held the position over a two year period and his level of income was high enough to disqualify him from receiving disability benefits. The employment experience was fraught with difficulties. George had stopped his psychiatric medication and the symptoms of his illness were slowly revealed. Although he received a sense of satisfaction in enhancing the quality of life for the seniors his enthusiasm eroded over time. The paranoia associated with his illness began to increase. His tendency towards emotional involvement with his patients persisted, affecting his judgement and interfering with his sleep (*G: "I kept seeing the faces of the patients on the unit"*) While coworkers praised his work his

personal evaluation of his competency was negative (*G: "I thought they were going to fire me for sure"*). George found the social atmosphere amongst coworkers to be generally hostile (*G: "...you could see the way they were divided among racial lines"*) and despite efforts to maintain emotional distance he believes this hostility added to his paranoia. The situation was the antithesis of his inclination towards sociability.

During this period George enrolled in a university psychology course on probation. While he managed to pass the course, his academic performance mirrored the decline he was experiencing on the job and reflected a more generalized loss of daily function:

> *G: I didn't do well in it because my illness was coming back at the time and I was losing interest in the course and then work...you know eventually I even ended giving up the apartment because I couldn't manage the payments on it anymore, eh? And I moved back home with my mom and that was a traumatic event.*

Taking things into consideration

George believes that in many ways he is now ready for work. His mental health has stabilized over the two years since his last hospitalization. He now takes his psychiatric medications regularly and in the context of psychotherapy he is moving towards accepting and actively coping with his mental illness. He did not intend a lengthy departure from the work force and he is incredulous that seven years have passed since his last regular job:

> *G: So it was a little over two years now that I've been off, that I've been out of hospital and I've been taking my meds regularly, I've been seeing my case manager, I've been seeing my psychiatrist. The only thing that, sort of getting back to what you were saying, it's sort of maddening you know. Like I didn't realize that 1992 was the last time that I worked at a regular job, and 1999, that's seven years in between you know and I haven't really worked at a full-time paying job outside.*

George has attempted several pathways for reestablishing a work career. For example he hoped to procure employment by attending a psychosocial rehabilitation program that offered transitional work placements following the development of basic work skills and habits. He was

disappointed that he was unable to gain the credit necessary for job placement. He is also wondering about the possibility of an affirmative employment job for consumers of mental health services or a perhaps a bursary to cover the tuition costs of a night course.

Case Analysis

1. Work recovery is best understood from a life course perspective.

> *G: I would just say that I'm thankful that I've been healthy enough that I was able to work. I was able to go to school because it adds to my whole spectrum of life experiences that I've had and I've made some good friends when I've worked.*

Examining George's work career from a life course perspective allows us to see beyond his present unemployment to appreciate the richness of his work related experiences, his continuing identification with work and how his relationship to work has evolved over time. His career has included a wide variety of work related achievements including many years in unskilled, physical labour jobs, participation in university studies, the successful completion of a community college diploma and employment in the human services. Even within his current seven year period of unemployment George has continued his participation in work related activities such as volunteer work, paid speaking engagements, and temporary labour jobs. Although he participates in a schedule of daily activities that he finds enjoyable and meaningful, he continues to be preoccupied by work related issues ("*G's case manager: George is always talking about work, always*").

While George's work career included significant periods of unemployment, overall it demonstrates a pattern of career mobility. That is, rather than a series of unrelated work experiences, George's career indicates a trend towards work related activities that were consistent with his personal vocational values and aspirations and to jobs that were increasingly responsible and required the development of a specific knowledge and skill base. Although he

regards it as a sign of achievement. it appears that this upward mobility now poses a particular dilemma for George. He is faced with the disconcerting task of deciding where on this career trajectory to direct his work efforts. a decision that is complicated by the length of his unemployment and his advancing age:

> *G: It was sort of like in limbo you know because of my experience on the psychogeriatic ward I don't really feel like working full time again and I wasn't sure if I wanted to work with seniors but then I didn't know what else I was qualified for and as I said I've done physical work in the past but after a while it got a bit tiring and it got a bit strenuous and I'm not in the best of shape as I was in my 20's. But now I'm finding that the physical labour is a bit too much for me. it's a bit too much. it's lifting. the carrying. the walking and stuff like that. so it sort of limits my job opportunities as I said you know.*

In addition to tracking George's development as a worker. the life course perspective facilitates an understanding of the relationship between work and his mental illness. The detailed examination of George's experiences across his career provides information about the interaction between specific work related qualities on his mental health. thus giving definition and meaning to the concept of work stress. For example. while George valued university education. he found that compared to university the higher level of imposed structure at the community college level helped him to maintain the sleep patterns that are so fundamental to his well-being.

Furthermore. the information in this case study traces the emergence of George's growing awareness of his strengths and vulnerabilities within the work realm. This case study tells a story of remarkable personal growth, from the early years of denying the illness and its impact on his work performance, to his present awareness of signs and symptoms of the illness and their relationship to employment and the development of active efforts to the manage health related issues:

> *G: I was really naïve then Terry. As I said I didn't know too much about the illness or how to cope with it. but over the years I've learned that right now I'm fairly stable and I know what I have to do to stay out of the hospital. just sort of watch out for my symptoms*

and watch out for early symptoms. But at that time I wasn't really that familiar with the illness and I didn't read much literature.

George's considerable achievements occurred within the context of an uneven career. His work time line reveals four periods of non-involvement in work related activities that lasted for more than one year. These periods all followed episodes of acute illness and psychiatric hospitalizations. They are characterized by the severity of his indifference and lethargy and appear to represent prolonged phases of reconstitution:

G: I would say five or six months you know. That's a long a period. Slowly. Because to get back all the skills that I had before. Like I would go through a period of pure lethargy, where I just slept and took the medication and of course I was on a pretty high dosage at the time and just made me drowsy and sleepy. But gradually I get tired of just staying and home and watching TV and not doing anything and I force myself to go out. But even then I find that...we were talking earlier about memory and concentration. It does take quite a long while before it comes back fully to the point where I'm writing in my journal. I'm writing short stories, articles. I'm reading. I'm functioning at the same level prior to my hospitalization. So it takes a while to build back up your skills and resources and stuff.

George himself describes these periods as work taking a "*back seat*" and his actions become largely directed by the illness.

It should be stressed that these periods are not isolated occurrences of the illness. Throughout his career George negotiated the interaction between the demands of work and school and the symptoms of his mental illness (Note on medical chart: "*He says his symptoms have always been present and states he has gone to school, worked and functioned despite them*"). Analysis of the data suggests that there are four interrelated factors that combine to contribute to these lengthy suspensions of work activity: the severity of the symptoms, lack of vocational direction; lengthy periods of hospitalizations and; medication side effects.

The escalation of George's symptoms was characterized by changes in both the quantity and the quality of the mental disturbance. His initial symptoms were related to his activity level and he experienced over stimulation and subsequent disruptions in his sleep patterns. If the hyperactivity progressed unchecked, the *"secondary symptoms"* of hallucinations and delusions appeared. Without adequate intervention these symptoms progressed to a *"critical point"* that involved a loss of perspective and rationality and, as this quote illustrates, left him unable to meaningfully participate in work related activities:

> *G: The issue was that I was a spy or something that was involved with the CIA or something like that. Because of the records that... the studies that we did at university were quite controversial at the time and I thought it was something...like they were keeping tabs on it, sort of as students, but it was sort of far fetched at the time. But when the illness sort of came back and it sort of got heightened you know, I would believe, actually I believed that people were out to hurt me too, you know. Even to physically harm me too, you know.*

The fear and the hostility that were engendered by these symptoms become so intense that George either sought out the protection of the hospital or he was admitted on an involuntary status. These hospitalizations become lengthy affairs. The process of medical stabilization required trials of new medications that sometimes resulted in severe reactions (G: *"I thought I was having a seizure, my arms went out, my neck got stiff, I couldn't move. Then my tongue was getting swollen"*) and high doses of medications that left George with disabling drowsiness. In addition, George himself was hesitant about returning to the environmental context within which his symptoms arose. Although the hospital stays focused on ameliorating his mental health, they alienated him from his colleagues and dampened his self-direction and drive:

> *G: But I think it was the long hospitalizations that really sort of ...you sort of became like institutionalized, like when you came out. I remember I would eat my meals at the same time they served meals at the hospital. I would take my medication at that time, the same time the nurses gave me my medication and I didn't really do much. It took me a long time to sort of get back my enthusiasm for life.*

The progression of his symptoms and the subsequent hospitalization lead to the disclosure of his mental illness at work and thereby compromised his identity on the job. It is unclear to what extent his colleagues could identify his unusual behaviour patterns or equate them with a mental illness, however George's impression is that his behaviours can be socially damaging and in the aftermath require "*the mending of the fences*":

> *G: Like when the symptom get full blown and out of control and psychotic and I'm hearing voices, and I'm delusional, it's...it's embarrassing to talk about sometimes because I do and say thing that normally I wouldn't do and when I get well and I'm recovering, sometimes friends say do you remember the time you said so and so and you said you did so and so. I say, oh yeah, now I remember and that's really embarrassing and even sometimes it gets past the point of embarrassment.*

The outcome of these turn of events was that George was reticent to return these work activities and experienced the recuperation phase without a clear vocational direction to facilitate his recovery efforts.

2. Positive meanings associated with the worker role facilitate the individual's ability to negotiate the stresses associated with the worker role.

George's reflections on his career indicate ambivalence with respect to the meanings he gives to work. His positive associations are focused on those work related experiences that provided a context for defining himself based on his strengths and abilities without primary reference to his mental illness:

> *G: It's a broader spectrum and I can go out and do things with other people and they don't need to know about my illness or my hospitalizations. Maybe, if I want to confide in them later on it'll be okay. But that was one of the attractive things about working at the restaurant. Nobody knew about my illness or the medications or the being in hospital and they just sort of accepted me as George, the worker.*

This power of work to make him feel like a regular person extended beyond the confines of the work environment to increase his comfort in the face of social obstacles within the larger

community (G: *You're able to sort of mingle and sort of socialize with other people who are from the ...social barriers, different economic classes but you feel comfortable with it*").

He valued work experiences where he enjoyed a sense of camaraderie with "*healthy*" coworkers and participated in a broad scope of social exchanges (G: "*You know they go to movie theatres, read books, go to concerts and stuff like that. It's more active and more healthy and more attractive really*"). His work related activities fulfilled his need for intellectual stimulation. When the work involved simple, physical tasks, he found this stimulation through his contacts with his coworkers. While immigration to Canada was the catalyst to actively struggle against the disablement associated with mental illness, work was the medium by which he came to develop and express his social and functional persona.

Similarly the economic rewards associated with work encouraged George's feeling of being "*on a level with other people*". The money he earned from work upgraded his standard of living. It allowed him to save funds for other work related opportunities, specifically college and university and it allowed him to enter community environments (i.e. neighbourhoods, stores, restaurants) where he could meet a wide variety of interesting people:

> *G: When I lived in the area and I was working at the hospital at the time, the first year, I made a lot of new friends because I sometimes ate at the restaurant at the corner there and there were a number of people who would come in for a coffee and a cigarette and sit at the counter and eventually it turned to idle chit chat. But then I found that they were interested in books and literature and music. They were interested in art. So I made some really good friends that way, productive friends who were involved in theatre and music, who were even actors and actresses and stuff like that.*

Payroll deductions and paying taxes identified him as a contributing member of the work force and legitimized his right to social assistance at times of unemployment:

> *G: I see the amount that they are taking out for the pension plan, the old age, you know the deductions I mean. So I feel hey, I'm contributing to the fund that I'll be receiving eventually*

if I do get hospitalized and I am getting money I don't have to feel so guilty as if I didn't work before.

Yet, over the course of seven years without regular employment George's life situation has changed in a manner that mollifies his resolve for regular employment. Although he would like *"to do something to get out of this rut"* he is hesitant to act in a way that may upset his recent mental stability:

G: But the thing is you know on the other hand the years have been smooth and even, there really haven't been major manic phases where I was out of control or needed to be hospitalized, but sort of smooth and even and not too many traumatic events, good relationships here and there you know, socializing, a bit of normalizing, but it does bother me.

Now settled on a disability pension and in his own rent geared to income apartment, George is concerned about the threat to his financial and housing security, should his mental illness affect his work performance:

G: When you think about it actually you do have the security at the end of the month. The money is deposited in the bank and although if you work, if I work I would be making more money but the fact that I get a cheque from the FBA or CPP at the end of the month regularly and the month is set, it doesn't change, whereas if I go, maybe I have a couple of sick days off or my cheque is smaller, my rent would go up, so those are things I have to take into consideration.

This threat to his basic socioeconomic well-being is compounded by George's perception that the benefits system would be unable to accommodate changes to his work status as the need arises (*G: "...it's getting much harder to get on FBA now, there are a lot more rules and regulations"*). This is an issue of considerable relevance given George's many hospitalizations over the last seven years.

Despite his significant education and work history George now finds himself *"in limbo"* with respect to a specific vocational direction. Over the past seven years he has considered many options. While he retains a strong interest in working with people, particularly seniors, George is

uncertain about his ability to maintain the emotional boundaries required in direct human service work. Experienced at unskilled physical labour and restaurant work, he believes that at 44 years of age he has lost the stamina required to handle these jobs:

> G: ...because I'm in my 40's right now and I don't think I'll be able to do the jobs that I did earlier, you know working in factories, warehouses. I don't think I'm in shape to do that.

In addition the prolonged period of unemployment has undermined his self-confidence by providing few opportunities to evaluate his job abilities (*G: ...but right now it's been such a long time since I've worked that I'm not sure what my capability of performing the job is.*"). This long period of unemployment presents him with the additional, unsettling challenge of explaining a long absence from the work force without disclosing his mental illness:

> *G: Although I feel I'm ready to go back into the work force, but how would I explain like the long gaps in between, like when I sort of... I don't want to tell the employer that I have an illness, that I'm on medication and stuff like that. But you know I would sort of have to you know tell white lies here and there to cover up the long gap in between.*

3. A central feature of work recovery is the individual's perception that it is possible to create a functional self-identity separate from the disorder.

For George the development of a functional sense of self in the midst of an ongoing mental disorder has been an evolving process. He is engaged in regular psychotherapy with his case manager, focusing on developing his sense of himself as a complex person with many dimensions, only one of which is the illness. He finds that a part of him continues to fight against accepting the illness and he struggles with the contradictions inherent in establishing an efficacious sense of self that integrates both his health and his illness. Although he understands schizophrenia as a persistent mental illness that can be controlled by psychiatric treatments and

self-help strategies. George wishes he was rid of the illness. In response to signs of health his pattern has been to terminate treatments:

> *G: Yeah, because part of it has to do with the denial but even to this day, I still have ...you know the fact that I have to take medication means that I have an illness but if I don't have to take the medication it means that the illness has gone away and I'm quote-unquote healthy and normal as anybody else. And that's my main fantasy or wish is that. So when I stop taking the medication it means that the illness has gone away so I can continue on with my life and go on and do other things.*

A particularly problematic aspect of George's struggle to construct an enduring and functional sense of self is the personal appeal of his delusions. These delusions provide him with a belief system that is empowering albeit unparalleled in reality and make it difficult for him to accept that they represent an illness that requires treatment:

> *G: Because part of it too is a bit of a glamorous side because like my delusion I believe I'm going to be a famous writer, a famous poet, a famous artist and I don't like going to the hospital. They're just going to take away my creativity, the medication is going to destroy and brilliant ideas I might have and stuff. So part of it is delusional.*

Overall George's limited acceptance of his illness has had a negative impact on his work career. Success at school or work provided him with evidence of his health and convinced him that he no longer needed the medications. His efforts to maintain a normalized perspective on his work related experiences limited his ability to consider the possibility that problems in his behaviour patterns or his social perspectives represented emerging symptoms. He was less inclined to seek early treatment for his symptoms and was then faced with a rapid progression to psychotic symptoms, the loss of rationality and subsequent hospitalization. These events continue to impact his work related activities. His unpleasant memories of illness related work experiences inhibits his motivation for work and constrains his work choices.

On the positive side George's participation in work provided a meaningful context for gradually learning about the interaction between himself, the illness and the broader world. The

review of data suggests that three aspects of his work career have made important contributions to George's ongoing efforts to define a functional sense of self: i) increased self-awareness of his personal strengths; ii) awareness of the work-illness interaction, and; iii) development of illness related coping strategies;

i) Awareness of personal strengths

Contrary to the images of individuals with schizophrenia, George has demonstrated his ability to manage the physical, cognitive and social demands of work. The completion of a college diploma affirmed his intellectual abilities and represented the fulfilment of the academic achievement values held in high regard by his family. In addition to contributing important information about his skills and abilities, his recollection of his past work career highlights the quality of the experiences as enjoyable and worthwhile (G: "*Like when I look back over the years, I say those were really good years because I was working part-time and taking course*").

These achievements provide George with valuable personal information that is instrumental in the process of developing a functional self-identity. His successful work related experiences encourage the acceptance of the mental illness while allowing him to distance himself from the identity of mental patient:

> *G: ...and as I said I'm thankful that I've had the work experience that I've had and being able to go back to school at time because there are some people that I talk to and I mean we're about the same age but they really don't have that much work experience or school experience and I kind of wonder what have they done with all the years in between. But it's not for me to say. Like maybe they were wrestling with their illness and maybe their symptoms are more drastic than the ones that I have, so maybe they're coping with it you know. But I'm thankful sometimes that the illness has taken a backseat and I was able to get on with my everyday life and do more things.*

George's awareness of his personal strengths facilitates his ability to construct a lifestyle that engages him in satisfying daily activities during times of unemployment. It also

encourages flexibility with respect to work, noted in the broad range of his occupational experiences (G: "*I have a lot of different interests so if something doesn't work at the moment I can switch to something else*"). Finally, this self-awareness assists George to imagine the possibility of future work related endeavours while maintaining an evaluative stance on their feasibility and their potential to improve on the quality of his life:

> *G: So the best idea would be just to take one or two courses and really concentrate and really work on them and get good marks and slowly build up you confidence and stuff you know. So that's one of one of my dreams for the future. to sort of finish my degree and see it through to its completion. But you know what. getting my diploma at college was you know. you know finally I saw something through to it's completion and I did the courses and you know I did it in three years.*

ii) Awareness of the work-illness interaction

Through his participation in actual work George has gained an understanding of the process by which specific aspects of work involvement interplay with his illness and threaten his ability to perform. The issue of daily structure is a common theme throughout his work career. He describes being sensitive both to work situations that place high demands on self-direction in daily routines and those work situations that require his participation into the evening hours. These features of work leave George vulnerable to night time arousal that disrupts his sleep cycle and induce him to engage in other evening stimulatory activities, specifically drinking coffee and late night wandering. This is a behaviour pattern that can quickly compromise George's rationality by inciting the experience of hallucinations and paranoia.

George is generally an affable man with a propensity for sociability. He finds, however, that he is susceptible to emotional over involvement in work related relationships that have poorly defined boundaries, such as those where he functions as a human service provider. This leaves him vulnerable to feeling under appreciated and even resentful when he believes his

effort and intentions within the relationship are not recognized. It also leads to disruptions in his sleep when the relationships preoccupy his thoughts. This situation can provoke his symptoms of paranoia.

George has found that a work environment that is characterized by social conflicts is a particularly noxious context for his participation. A climate of interpersonal conflict interacts with even subtle presentations of his paranoia to heighten his experience of the conflict and feelings of suspiciousness and resentment towards coworkers. The thoughts and the feelings associated with the paranoia undermine his personal sense of competence in the work environment and subsequently lead him to interpret the conflictual social dynamics as an indication of his poor performance. Left unchecked the situation progresses to the point where George's behaviours are observably peculiar and provide further evidence to support his evaluation of a hostile environment.

George describes the appearance of his paranoia in work situations as insidious, although once his behaviours become observably irrational the associated symptoms escalate quickly. An early indicator of the paranoia appearing on the job is the decline in his enthusiasm for the work. Leading to a decrease in his output of effort, this emotional retreat from the job further supports his inclination towards critical self evaluation that subsequently fuels his loss of interest:

> *G: I think it was a combination of both because one of the reasons why I quit was that I felt that I wasn't doing the job well. Although it may have been a misconception on my part because the first year that I went there, you know the doctors and the nurses were saying you're really helpful, you are one of the best workers we've had in a while. Because I was really active and enthusiastic about the job. But being there for a while my enthusiasm went away and after a while I felt that I wasn't doing my job properly and I didn't want to be there, you know. So that was one of the main reasons why I handed in my letter of resignation. But it could have been my misconception because my thinking was a bit confused at the time.*

iii) Illness related coping strategies

The emergence of undesirable and performance threatening symptoms within the work environment encouraged George to take an active stance of self-management and to develop specific coping strategies. He became particularly adept at counterbalancing the over stimulation of hectic and fast paced work environments by pacing his own performance and using his part-time status to allow for periods of rest and low activity. Similarly, he learned to direct his efforts to maintain a sleep routine that was calming even when presented with the alternative of participating in highly desirable social activities:

> *G: I made friends with some younger guys there and after work they wanted to get something to eat. And I went with them a couple of times but eventually I stopped doing it because by the time we finished eating it would be like 4:00 in the morning and by the time I would get home it would be early dawn and by then the day is starting and then I would be sleeping during the day and be working at night time so that was not productive to my mental hygiene. So I had to be a bit careful about staying up a bit late. Of course in a way it was really exciting because they were a young group and sometimes they would bring cards and we would stay up and play cards. But eventually it took a toll on me. I couldn't you know.*

4. Internal locus of control, self-esteem and commitment are psychological factors associated with work recovery.

George's case study illustrates the complexity of personal coping resources as they present in the context of the recovery of work in schizophrenia. These psychological factors, self-esteem, locus of control and commitment, do not present as stable personal characteristics within this case study. Rather, they emerge as identifiable periods of psychological function intertwined with distinct themes related to negotiating a functional sense of self within the work context.

The case study information demonstrates that George experienced distinct periods of functional immobilization following hospitalization for the acute symptoms of the mental illness. He describes his experience during these lengthy periods of inactivity as characterized by a lack

of vocational direction, drowsiness, cognitive impairment, and a general sense of inertia. George's transformation to active involvement in work related activities was triggered either by: 1) external events that demanded that his active involvement (for example, the family's move to Canada), or; 2) the reconstitution of his personal strengths to a critical point where he experienced his lifestyle as boring and empty and became open to opportunities for intellectual and physical stimulation.

An integral aspect of George's progress in work function following periods of illness and inactivity were the positive changes to his sense of self-esteem and his personal sense of control and effectiveness. His recognition of the success of his efforts and his enjoyment of his work fueled his commitment to sustain his involvement and to manage related challenges. This process of psychological empowerment was uneven and precarious to the extent that it depended on evidence that would support a self-view that essentially rejected the presence of a pervasive and persistent mental disorder. For example, George learned to recognize the impact of work involvement on his activity level and to schedule himself accordingly. However, he denied the emergence of psychotic symptoms and these would increasingly undermine his ability to sustain employment. He also consistently concealed information related to his mental disorder in work related situations in response to the internalization of his perception of the public stigma. It is important to note that George never attempted to return to previous work environments once the illness was disclosed, even when his performance conferred on him a measure of credibility as a worker.

5. **The individual's perception that valued people believe in his/her potential is associated with work recovery.**

George's family has been ambivalent about his involvement in work. Reports from the medical records indicate that they were lead to believe, very early in the history of the mental disorder, that there was a strong association between the pressures of schooling and the exacerbation of symptoms. Following acute episodes of the illness they provided him with shelter and sustenance but, unfamiliar with the nature of schizophrenia and lacking in practical information about managing the illness, they tended towards minimizing expectations and towards overprotection:

> *G: ...but basically I didn't do very much you know because... I don't know, like my older brother and my older sister they had to work in the shop to help my mom and dad, but I guess my mom was trying to protect me. She didn't want me mingling with the sort of people who came into the shop and stuff like that.*

Interestingly the high value placed on academic achievement within George's family, combined with their strong work ethic, motivated his educational and employment endeavours without delimiting his choices. For example, his move from university to college level studies was acceptable within the family value system as were his efforts at unskilled labour jobs. George experienced his family members as largely supportive of his work related efforts. At times, throughout his career, they provided him with shelter, finances and contributed to his daily self-care. At this time, his case manager believes that there is no pressure from his family to work.

Although George has now come to recognize the ability of family members to detect the emergence of symptoms of the illness, George has historically been unwilling to accept their observations and to seek early treatment. When acutely ill, George's behaviour can be severely disturbed and disconcerting within the context of the family. Currently his family is encouraged by the stability of his mental health and psychosocial well being and George perceives that they

are cautious about the appropriateness of his involvement in competitive work. Rather then representing a lack of belief in George's abilities, the family perspective appears to be directed to maintaining a state of emotional equilibrium both with respect to his illness and his level of autonomy:

> *G: Because in the past she has been happy when I worked but she was a bit doubtful of like with the illness would I be able to work because there have been some times that I mentioned I was thinking of getting a job here and then she says why don't you stay on the benefits and stuff you know. At least she knows that I have some security and the peculiar thing with my mom is that she almost has like a sixth sense of when I'm getting ill. Because in the past when I've been hospitalized I remember weeks before when I'd gone off my medication but I didn't think that the symptoms were that noticeable she'd say maybe you should go see the doctor or maybe you should go see the case manager and I'd say , oh you don't know what you're talking about, there's nothing wrong with me.*

A remarkable feature of George's social network is the presence of one consistent professional, his case manager, who has served as a champion for his work related efforts. When he has been engaged in work the focus of the therapeutic relationship has been on assisting him to maintain his work involvement by encouraging a shift away from his self image as a patient *(G: "...my case manager was saying oh now you're working with seniors and you're working with psychiatric patients and stuff, so I was oh wow I'm a senior now, I'm a colleague now")*, praising his efforts to encourage his perseverance and providing advice for dealing with the interaction of the illness and work *(G: "...and she said you know try to pace yourself not to get over excited, take your medication and learn to pace yourself")*.

A particular focus of the relationship was related to managing the socioemotional aspects of employment. With his case manager, George engaged in *"perspective sharing"*, to evaluate his interpretations of troublesome social situations and role playing to practice potential interpersonal strategies. These efforts were directed at the deliberate transference of knowledge

and skills to facilitate the self-management of problematic situations. For example, the processes involved in recognizing and maintaining interpersonal boundaries were approached as a skill that was within the realm of George's abilities.

Throughout this most recent and lengthy period of unemployment this professional relationship has been aimed at encouraging and even arranging for George's involvement in meaningful daily activities while solidifying George's self-identity as a complex individual. The focus has been on accepting the mental illness but affording it the status of *"only one aspect of me"*. George's case manager refers to this process as *"the teaching of himself"*.

> *G: ...and this I take from my case manager, it's sort of like a pie and the way you divide it up. Like how much of the pie is going to be the illness that you're going to concentrate on?*

An inherent aspect of this psychotherapeutic approach is assisting George to resolve the issues and memories of previous work experiences and encouraging George's understanding of himself as an active strategist in the management of his own well being. While this professional relationship reflects a strong belief in George's potential for work recovery, it also conveys the importance of consolidating his self-identity in relation to the illness as a precondition to realizing this potential.

An important consideration is the extent to which George's psychiatrists are absent from the story of his vocational efforts. It does not appear that they are unsupportive of his efforts. Rather their medical reports indicate a focus on the treatment of his illness through psychiatric medications. There is a notable absence of reference by psychiatrists to vocational issues, and a lack of documentation indicating the direct exchange of information and strategies related to the work-illness interaction.

6. **An integral feature of work recovery is the individual's appraisal of employment as essential to mental health and well being.**

George finds that work has a double edged effect: It has the capacity to be both beneficial and detrimental to his mental health. On the positive side, he believes that work has the capacity to decrease the primacy of the illness by focusing his involvement on a broader range of daily routines while distracting him from the preoccupations of the disorder:

> *G: I think in a way it does sort of put it aside for awhile because you know, as I said before in the past, like even when I was discharged, when I was in the smoking section of the cafeteria there, a lot of the out patients and even the in patients would come there to have coffee, but the main thing they talked about was their illness and the diagnosis and the medication. But when I'm working outside in the work force and people don't know my illness and the medication, they talk about everyday events that are happening or trips they have taken, or movies that they have seen. It's a much more healthier environment and I think it really helps to sort of lessen the illness a bit. You're not aware of it.*

Work provides George with a meaningful context for participation in goal directed activities. This influence of work positively impacts on his mental health on several levels. It demands his attention to basic self-care, an area of function that typically suffers in the aftermath of an acute episode of his mental illness (*G: "...you walk into a job interview you have to be well dressed, well groomed and stuff I mean."*). His motivation for success at work directs him to actively contain the symptoms of his illness:

> *G: Looking back I can see sometimes I got a bit high, sometimes a bit low, but the swings and moods weren't that extreme you know. I guess it was because I had to remain relatively stable to function in a work environment, eh?*

Finally, the order of the work day organizes his days and weeks into a more balanced interaction between distinct periods of productivity, leisure and rest and subsequently leads to a normal night pattern of sleep that he finds imperative for his *"mental hygiene"*.

Work also positively influences his mental health through its impact on his self-esteem. The experience of being employed raises his self-confidence thus facilitating an active stance to apply himself to challenges (*G: "You feel more capable of doing things and you're not as scared of taking risks anymore, like I mean even social risks"*). Work situations that capitalize on his strengths, both in the task and social domains, are particularly likely to provide him with the ongoing positive feedback he requires to sustain his perseverance. It is important to note that George's self-esteem within the work situation has depended on the presentation of a work identity without reference to the mental illness. George has never disclosed his illness in a work situation, nor has he returned to any work environment once his illness has been revealed.

On the negative side, George finds that prolonged periods of work lull him into a false sense of invulnerability to the mental illness. He tends to interpret his work success as evidence that he is free of the schizophrenia and no longer in need of psychiatric treatment. The outcome has inevitably been lack of adherence with his treatment regimen and the subsequent exacerbation of his symptoms:

> *G: And I should mention that that's one of the major reasons why I ended up back in the hospital was that I went off my medication because what happened was that after I got discharged from the hospital I would take my mediation religiously. I didn't want to end up back in the unit again and then after about two or three years and I have been doing well on the medication and working and going to school, like I've told you, Ill say okay, maybe I'm better now. I don't need to take as much medication, so I start reducing until finally I was taking the barest minimum.*

The case study suggests that specific features of work are detrimental to George's mental health. He is particularly sensitive to work situations that encroach on his regular routine of sleep, although he appears to have developed effective strategies to neutralize their effects. The symptoms of his illness appear to be provoked by unstructured work environments that depend on high levels of self-direction and self-evaluation. Similarly his paranoid symptoms are

enhanced by work tasks that occur within the context of work environments with hostile social climates and social relations with ambiguous boundaries. These latter work stresses appear to be particularly unresolved issues for George, and continue to undermine his enthusiasm and resolve for work.

Summary

This chapter has presented the description and analysis of a forty-four year old man diagnosed with schizoaffective disorder, who has been without regular community based work for seven years. Although George's occupational mobility has been derailed, his work life can be characterized as a career with a variety of work related accomplishments.

Despite seven years without regular community based employment he has continued participation in work and purposeful activities. These activities facilitate his ability to guard against the appearance of psychotic symptoms by constructing a work ordered day.

Acute episodes of the schizophrenic illness, accompanied by hospitalizations, sever George's involvement in work. Reconstitution from these episodes is a lengthy process. The transition from the inertia experienced following the acute episodes to involvement in work related activities is particularly difficult. There is evidence of a negative cumulative effect of repeated acute episodes on work involvement. The exacerbations of the illness reflect his fundamental inability to accept the illness as an accurate interpretation of his experiences. This has a negative influence on his ability to understand and manage the illness experience in relation to his fulfilment of the demands of work. George has been highly invested in maintaining the identity of a "regular" worker and this interferes with his ability to identify the illness experience within the work context. He has demonstrated the uneven management of signs and symptoms of the disorder and has particular difficulty dealing assertively with

psychotic symptoms. Work situations that are characterised by hostile social dynamics, and interpersonal relationships that lack clear emotional boundaries interact with his psychotic symptoms to present as a significant work disability. He continues to harbour negative feelings towards several of his past employment situations and this increases his current ambivalence towards work.

While George associates work with several positive meanings his resolve for work is weakened by his inability to reconcile an acceptable self-identity that integrates the illness, and to subsequently negotiate the work-illness interaction. George's motivation is further weakened by the financial instability he associates with work. This view of work as threatening is encouraged by significant others in George's family network who have over the years, come to associate his participation in work as provoking his illness and disruptive of family relationships.

CHAPTER 6

CROSS CASE ANALYSIS

Introduction

This research used a qualitative, multiple case study methodology to examine the process of work recovery of individuals diagnosed with schizophrenia. This chapter will present an analysis of the findings across all three cases to advance the theoretical base for the process of work recovery in schizophrenia.

Theoretical Propositions of Work Recovery

1. Work recovery is best understood from a life course perspective.

Approaching these case studies from a life course perspective allows us to view the configuration of the individuals' relationship to work as it evolved over the course of time. The particular strength of this perspective is its ability to facilitate a holistic analysis that led to the identification of distinct but interrelated patterns that characterise the work life of these three individuals. Specifically the analysis revealed the following four longitudinal patterns: i) the centrality of work; ii) the coexistence of work and mental disorder; iii) the presence of career mobility within a non-linear trajectory, and; iv) the transactional nature of the person-work-environment relationship.

i) The centrality of work

These case studies support previous research findings that individuals with psychiatric disabilities place a high value on work regardless of their actual employment status (Lord, Schnarr & Hutchison, 1987; Downs, 1989). This commitment to work went beyond psychological desire. All three of the study participants demonstrated involvement in work related and purposeful activities during periods of under employment or unemployment.

First they were involved in purposeful activities including crafts, hobbies, sports and volunteer work. Involvement in these activities appeared to serve two purposes. It provided them with a structure that resembled the work ordered day. This structure was particularly important in maintaining a sleep-wake cycle that was consistent with the broader community, an outcome that served to decrease their social marginalization and their vulnerability to the exacerbation of symptoms. While this is particularly illustrated by George's efforts to organize his time without regular work. Winston's experience of under employment also left him vulnerable to the negative effects of periods of unstructured time. Participation in meaningful activities also provided them with an avenue to operationalize their strengths and abilities and subsequently to provide them with evidence of their competence and continuing growth. For example, Ann experienced purposeful activities as the only outlet for the expression of function during her lengthy periods of institutionalization.

Although the importance of purposeful activities in the lives of individuals with schizophrenia has been addressed in the literature (see for example, Kirsh, 1996; Vorspan, 1992) these case studies highlight the difficulties inherent in establishing a structured routine of activities outside of the work context. While these purposeful activities are characterized by flexibility and accommodation that is not typical of competitive employment, they do not carry with them all of the positive meanings (i.e. income, social integration, productive social contributions) or the consistent routines that are associated with work in the community based labour force. George's case in particular highlights the difficulties inherent in organizing a structured and yet meaningful day without regular work.

Second, the participants were involved in efforts to construct a vocational direction. These efforts included both the contemplation of work related possibilities and engagement in work

related activities, such as trying out a job or applying for work, in an effort to consolidate a satisfactory vocational path. Inconsistent with theoretical orientations that assume that difficulties with vocational direction represent a primary symptom of schizophrenia (see for example Andreason & Flaum, 1991; Andreason, 1982), these case studies are more in keeping with explanations that focus on the extent to which the experiences associated with the mental illness can eclipse consistency in the development of the work identity and provoke associated problems with self awareness and confidence in the work realm (Bebout & Harris, 1995).

Finally, all of the case study participants were engaged in occasional paid work that could not be easily understood within traditional conceptualizations of regular employment in the community based labour force. These "jobs" included temporary employment positions and involvement in teaching high school students and mental health professionals about the experiences of mental illness. Estroff (1995) found a similar pattern in a longitudinal study of 169 persons with severe and persistent mental illness and suggested that this phenomenon represented an important source of socialization and financial enhancement for individuals who are socially and financially marginalized. She hypothesized that the dismal employment rates for this population may be, at least in part, an artifact of value laden definitions of employment and inadequate methodologies.

ii) The coexistence of work and mental disorder

The life course perspective captures the extent to which the co-existence of working and persistent symptoms of the disorder may represent the norm across the work lives of individuals with schizophrenia rather than discrete or isolated events. George, Winston and Ann experienced refractory symptoms of schizophrenia even when following medical therapeutic interventions. Furthermore rehabilitation approaches that focus only on how

schizophrenic symptoms influence work performance appear to inadequately represent the extent to which the mental disorder influences the work experience. In these case studies the features of the illness permeated decisions to return to or to terminate work, career choices, interactions within the work environment, and lifestyle choices outside of the work place. Managing the coexistence of work and mental disorder is particularly daunting when it is understood that individuals largely navigated the demands associated with work covertly, whether or not the illness has been disclosed in the work place.

The work life perspective provides an opportunity for the closer examination of those occasions when the individual's relationship to work was severed. The exacerbation of acute psychotic symptoms initiated the complete withdrawal from the community based labour force. The studies reveal a critical point at which the psychotic symptoms of schizophrenia become so pervasive as to obscure rational thought, effectively destroying the individual's control of work related behaviours. These episodes threatened established work situations through ineffective task and social performance and also through unmanaged disclosure of the illness. Winston, George and Ann appraised these exacerbations as a threat that could lead to a lengthy period of recuperation, perhaps confounded by the experience of institutionalization, medication trials and related side-effects, cognitive impairments and an overall sense of lethargy and inertia.

Strauss and his colleagues (1985) identified this prolonged period of recuperation and the accompanying social and occupational marginalization as a universal phenomenon following episodes of the disorder. These investigators found that this period represents a period of subtle growth within the context of reconstituting from the mental disorder. However, all of the participants in this study experienced it as particularly damaging to their

work careers. whether or not they managed to maintain their work situations. They highlighted the importance of recognizing and halting the progression of symptoms. These case studies suggests that repeated. acute exacerbations may have a negative cumulative effect on the individual's psychological preparedness for work. the return of pre-morbid functional capacities and on social resources that enable the individual's employment. For Winston. George and Ann. the occurrence and the impact of these exacerbations appeared to be more related to the lack of adherence to medical therapeutic interventions and failure to actively secure early treatment rather than the severity of the illness or poor treatment response.

iii) Non-linear pattern of career mobility

A striking feature of these case studies is the extent to which their work lives can be characterised as careers. That is. their job efforts reflect a pattern of progressive achievements. training and skill development in a chosen field. The concept of career receives little attention in the literature relating to work and schizophrenia. The predominate view that the work involvement of the population reflects discrete events may be at least partially explained by cross sectional methods that fail to attend to the interrelationships between work experiences. In addition. their progressive achievements within the work realm are perhaps easily shadowed by very subtle and uneven changes in work position and responsibility and by the generally low financial status of their jobs.

The case studies illustrate that involvement in a career is by no means a guarantee of work recovery. In fact. it appears that the outcomes related to involvement in a career largely depend on their meanings within the framework of the broader work life. All three case studies illustrate that career involvement may exert a positive influence on work recovery through the positive

self-concept that is associated with personally valued work and the opportunity for the development of skills. It may also have a negative impact on the individual's psychological preparedness for work if, as in George's case, efforts towards a career are derailed after considerable effort.

iii) Transactional nature of the person-work-environment relationship

These case studies suggest several patterns of individual-environment transactions that influence the process of work recovery. The first is the extent to which achievements and progress within the work realm influence subsequent positive changes in the individual. This occurs through the direct reinforcement of personal competency and indirectly, by eliciting the supportive efforts of other individuals in the environment. For example, Winston's initial efforts at work provided him with important information about his work abilities and limitations while confirming his sense of himself as an active agent in his own well-being. Simultaneously, his efforts engaged both the emotional and practical support of his educators and mental health professionals towards the achievement of his work goals. Certainly, the analysis supports the findings of other studies that highlight participation in work activities as personally empowering and a powerful source of intrinsic motivation (Csikszentmihalyi, 1993; 1990; Kirsh, 1996; Lord, 1991, Lord & Hutchinson, 1993). Of course, this pattern can also occur in the reverse, as illustrated by Winston's negative work behaviours within a rehabilitation programme inconsistent with his own values. The experience evoked both intense psychiatric symptoms and a negative view of his employment potential from rehabilitation practitioners.

A second pattern is the extent to which changes in the broader work related environment can influence work recovery. All three case studies highlight that work environments are ever changing and that these changes can significantly alter the individual's work status. For example,

Ann experienced advancement on the job with the change of an immediate supervisor, while Winston's desire for more regular work was blocked by the elimination of the permanent part-time job category by his employer. Similarly the case studies highlighted the influence that changes within the mental health system can have on work recovery. A recurring theme among the study participants was the benefit of the system's move to community and vocationally oriented services that actively supported their efforts towards the community based labour force.

It is also important to note the extent to which the career options considered appropriate for people with schizophrenia have increased. Ann, for example, was rejected in her adolescence from a nursing assistant course because of her experiences with mental illness. She was subsequently offered training in a similar position by her present employer, familiar with her diagnosis, in response to the restructuring of the medical records department. Similarly, Winston and George experienced the job search as enhanced by the addition of affirmative employment positions in the social services for qualified people with psychiatric disabilities.

Finally, all three case studies suggest that the individual's engagement in a variety of different work situations is beneficial to work recovery, if understood from a growth and learning framework. This variety of work involvements provided the opportunity for a broad based awareness of interests, strengths and limitations that ultimately assisted with the development of vocational choices. Furthermore, these work experiences provided individuals with the opportunity to witness the universal struggles associated with employment. These examples served as a point of comparison for those difficulties associated specifically with aspects of the mental disorder and work.

These work experiences also appear to protect the individual, to some degree, from the social and occupational void that is intrinsic to periods of unemployment or underemployment. They

facilitate the individual's awareness of and accessibility to a range of potential activities available outside of the work realm. George, for example, considered himself better able to deal with the lack of structure inherent in unemployment because of his varied work experiences.

2. Positive meanings attached to the worker role facilitate the individual's ability to negotiate the stresses associated with the worker role.

The case studies highlight a range of positive meanings associated with work in the community labour force. While these positive meanings are similar in form to those expressed by the general population (see for example Simon, 1997) the data reveal considerable specificity to the experience of working with a mental illness. They provided a source of motivation for negotiating the demands of the work experience.

The following five distinct positive meanings were revealed from the case study data:

i) Realization of values and goals

The study participants were raised within families that valued the normative ideal of employment as an important measure of maturity and success. Prior to the diagnosis of mental illness, all of the study participants expected that their lives would progress to include participation in adult work, although the clarity of the work goal varied between individuals. Their initial contacts with the mental health system marked the beginning of the disruption of their personal career development and were a source of considerable upset and despair within the broader family context.

The individuals' reengagement in work provided an opportunity to fulfil the expectations of the work ethic. Participation in community based work averted the dilemma of constructing a meaningful life outside of the social norm (Godschalx, 1987 in Hatfield & Lefley, 1993; Bebout & Harris, 1995; Pettie & Triolo, 1999). The ensuing work history may not have exactly reflected

the expected ideal of the individual or the family. Yet, the data reveals that the central values and goals remained as common threads that informed the various choices and adjustments the individuals made throughout the course of their work lives.

Participation in work provided the individuals with a sense of historical continuity by establishing connections to earlier values and goals associated with a time of relative health and well being. Work served as a source of pride in achievement and competence. Indeed, work functioned as a particularly powerful measure of success with its explicit and often formalized recognition of achievement (for example, graduation ceremonies, diplomas, performance appraisals and promotions). Similarly involvement in work served as a corrective experience for critical incidents or situations that the individuals perceived as particularly disparaging or socially marginalizing. While this was particularly notable for Winston who viewed work as a source of vindication for his criminal activities, all three of the case study participants experienced work as evidence of their achievements in the context of rivalry with a sibling.

ii) Social reciprocity

The social networks of the case study participants were typical of individuals with severe psychiatric disorders. They were characterized by few interpersonal contacts and were largely kin or professionally dominated with the illness retaining a central position in defining these relationships (Gillies et al, 1993; Gottlieb & Coppard, 1987). Unlike the traditional views that assume social isolation and alienation to be primary symptoms of schizophrenia (American Psychiatric Association, 1994), the three case study participants were oriented positively to social relationships and valued the opportunity to engage in work interactions marked by equality and reciprocity. The data suggest that, at least for some individuals with schizophrenia, social withdrawal may be a consequence of the lack of opportunities to participate in socially

integrative roles such as work. This is in keeping with the findings of first person accounts (Lette. 1993; Boricius.1989) and phenomenological perspectives (Davidson & Staynor.1997) that demonstrate that individuals with schizophrenia have a profound desire for social relationships.

Work allowed the case study participants to engage in reciprocal relationships with both coworkers and customers while the mental illness remained largely superfluous. They were able to both give and receive respect. collegiality and even affection within at least some of their work relationships. The impact of these relationships extended beyond the immediate work situation and served as a foundation to encourage reciprocal interactions within their existing social networks and within the broader community context. Ann. for example. took on care giving functions for her parents and nieces. while work enabled George to interact with individuals from a broad range of interesting careers.

The experience of reciprocity carried on to the act of carrying out the tasks of the jobs. Fulfilling the demands of the job provided evidence of a significant contribution within a meaningful work context. Each of the participants viewed their work as worthwhile to society. even if they disliked particular tasks or activities associated with the job.

Finally the case study participants perceived that their participation in work made a broader societal contribution. They each highlighted the personal importance of contributing financially back into a system from which they have been forced to draw for health care or economic subsidy. They also understood their experiences of working with schizophrenia as unique and assumed a responsibility for inspiring others with the mental illness and their families and for promoting public awareness and education.

iii) Identity validation

A predominant theme was the capacity for work to provide a legitimate self-identity that was not associated with the mental illness. Within the work situation interactions were largely defined by performance expectations. Acceptance on the job was based on the individuals' capabilities. This served as a stark contrast to the experience of being a mental patient, an experience that was largely organized around personal limitations and constraints. Work provided an opportunity to understand performance related problems on the job as a universal phenomenon. For Ann and Winston, the sense of personal worth and credibility was particularly powerful when acceptance within the work situation was experienced despite disclosure of the illness.

The data suggests that this positive identity extended beyond the work situation and facilitated the transformation of other social relationships. So for example, Ann came to be viewed as a source of stability within the family, while Winston found it difficult to reconcile the feelings of guilt associated with transcending the position of his friends within the mental health system. All three of the participants perceived that work transformed the nature of their relationships with mental health professionals, moving from a patient-therapist relationship to one of collegiality and shared expertise. While this was generally experienced as empowering, this change in the client-therapist relationship engendered some stress in George who felt that his performance on the job could disappoint his therapist.

These case studies raised questions about possible gender based variations in the struggles to develop a work identity. While all of the participants engaged in a lengthy process of identity adjustments and refinements, only the female participant presented her current work identity as a purposeful compensation for her perceived inability to fulfil the expectations of

marriage and motherhood. Interestingly, her participation in work facilitated the establishment of a close relationship with her nieces, both financially and as a caregiver, and thereby provided her with some of the benefits she associated with nurturing a family. The males in the study, while positively oriented to attaining companionship and intimacy, did not relate this to their worker identity.

iv) Framework for daily life

While work has been viewed as an important source of daily structure for individuals with schizophrenia, these case studies provide a richer meaning for involvement in work activities. Work provided participants with a direction and a sense of organization to daily life that approximated the temporal rhythms of the broader community. While the daily routines of the individuals did not reflect a clear balance between self-care, work and leisure, participation in work did imbue non-work hours with meaning and purpose. Work provided a guarantee that a dedicated portion of the individual's time would unfold within the context of social interactions and well defined, meaningful activities. The participants viewed unemployment as a void, with the potential to engulf them in despair.

v) Earning a living

Work provided individuals with the reward of receiving a paycheque for their efforts. The monetary reward associated with employment was valued for its contribution to self-sufficiency and autonomy. The income provided them with the ability to access a broader range of resources, including participation in hobbies, ownership of a vehicle, and the enjoyment of community resources such as the occasional restaurant meal. However, the participants were primarily involved in low paying jobs that imposed significant financial limitations regardless of the actual

number of hours worked. In fact all of the participants depended on other sources of income or shared resources to meet their basic needs in the community.

It is important to note that their income remained low despite considerable college preparation or skill training on the job and did not substantially improve with years performing successfully in the job. Only Ann was engaged in employment that provided health and retirement benefits. While their low income was not a direct result of the illness experience. it appeared to be an indirect outcome through the adjustments to vocational goals. reduced hours at work and the inability to progress through the employment ranks.

The financial underemployment of persons with severe mental illness has recently received attention in the mental health literature. Questions have been raised about the extent to which individuals with schizophrenia can afford to work without other forms of economic support (Baron. 1999; Polak & Warner. 1996). An ethnographic study by Alverson. Alverson, Drake and Becker (1998) identified a basic level of material wealth as an important correlate of competitive employment among individuals with severe psychiatric disorders such as schizophrenia.

The study data also suggest that the enabling qualities of these positive meanings can be counter balanced by the individual's negative associations with work. In the wake of recurring episodes of loss of control to the disorder. the meanings associated with work may be transformed. Within the context of repeated failures and unresolved conflicts on the job. work can become viewed as a hostile and threatening situation. as it did for George.

The case studies illustrate several ways that work may come to be viewed as threatening and thereby weaken the motivation and the resolve to persist. First the perception of failure on the job reinforces the sense of inadequacy. These individuals appear to be particularly vulnerable to

the toxic psychological impact of failure as it interacts with their ongoing struggles with internalized stigma.

It is important to note that it is the individual's perception that appears to influence meaning and not necessarily the objective presentation of failure. George for example, was unwilling to return to work situations that were terminated by an exacerbation of the illness even though he may have been welcomed back by the work environment. Within this framework, failure may be more broadly understood as including an individual's lack of success in managing the presentation of the illness, rather then the job itself. So for example, George refused psychiatric treatments and viewed his work participation as evidence of personal health but came to appraise work participation as the source of his difficulties when he experienced a relapse.

The view of work as threatening may become reinforced by significant others in the social network who are necessarily affected when an individual's involvement in the work environment goes awry. Consider, for example, that George's social network was called upon to resolve immediate financial crises in the wake of unemployment and feared for his safety as they observed an increase in symptoms that they came to associate with work involvement.

Finally, individuals who repeatedly disengage from paid work situations are actually at risk for financial instability. The work disincentives created by government disability pensions are well known (Noble, 1998; Polak & Warner, 1996). Certainly all of the case studies provided evidence of the extent to which disability benefits can undermine attempts at recovering work function. In particular individuals and their families lack faith in the system's ability to efficiently respond to changing financial needs. Mental health professionals, and particularly the physicians, appear to be caught in the dilemma of having to simultaneously undermine the

individual's self-image as worker in order to ensure the individual's financial well being through access to disability pensions.

The analysis suggests that a primary evaluation of work as a source of threat may represent an individual's difficulties in resolving the conflicts inherent in working with schizophrenia. Distancing oneself from employment, or conceptualizing work as the source of the problem may enable the individual to avoid a situation that provokes critical self evaluation in the midst of a mental disorder that already undermines the individual's self-esteem. George, for example, has chosen to continue his recovery outside of the context of the work domain, where there is more flexibility and fewer pressures to manage the tasks of working with schizophrenia.

3. A central feature of work recovery is the perception that it is possible to create a functional self-identity separate from the disorder.

The case studies suggest that this theoretical proposition is an inadequate representation of the processes involved in work recovery. The proposition does highlight the central dilemma of developing a functional self-identity in the presence of a schizophrenia. These case studies suggest that beyond developing an identity separate from the disorder the fundamental task of work recovery is the integration of the person, the mental disorder and the work context across the career trajectory. Integration is described as the individual's development of a self-identity in the work realm that reconciles and adapts to the illness experience.

Furthermore this integration is of an ongoing and evolving nature. The case study findings are consistent with perspectives that argue the need to conceptualize the individual's continuing personal development within the context of the illness experience (Strauss; 1989; Davidson & Strauss, 1995; Deegan, 1988) and across a variety of life domains (Strauss & Carpenter, 1974).

A recurring theme across the case studies is that fundamental to the work recovery process is the individual's acceptance of both the diagnosis of schizophrenia and of the personal responsibility to manage the disorder by adhering to prescribed psychiatric medication schedules. The ongoing stabilization of the symptoms by medications was regarded by all of the case study participants as the fulcrum that supported efforts towards work. A full discussion of the issues surrounding the issue of acceptance are beyond the scope of this thesis, although it should be noted that coming to terms with the illness and its treatment was a longstanding, complex and emotionally charged issue for all of the participants. Clearly a threat to their personal sense of well being and their sense of functionality and normality, the process of acceptance was complicated by factors such as disturbed family relationships, impaired thought and affect, involuntary hospitalizations and troubling side-effects.

While other investigations have supported the importance of acceptance of the diagnosis and medical treatments for success within the work domain (Scheid and Anderson, 1995) there has been a tendency to view acceptance rather narrowly as the individual's agreement with biomedical interpretations of manifestations of the disorder and as a phenomenon that is distinct from the individual's work life. A few research studies have examined the relationship between work and insight. They have suggested that involvement in rehabilitation activities improves the self-awareness of the disorder and the need for treatment (Lysaker & Bell, 1995b) and that it does so by raising self-esteem and subsequently increasing the security necessary for these insights (McEvoy, Schooler, Friedman, Steingard & Allen 1993).

The case studies suggests that the concept of acceptance is misleading in its simplicity. The concept of integration, and specifically integration of the person, the illness and the work life more accurately represents the individual's experience of work recovery. Integration within

the realm of work is an evolving process that can be characterised within three distinct but interrelated components: i) phases of integration; ii) the evolving nature of the individual's experience of the disorder. and; iii) work influences on integration.

i) Phases of integration

Consistent with longitudinal studies of the course of major mental disorder (Strauss. et al. 1985) and recovery from severe disabilities (Lord, 1991) this analysis suggests the presence of distinct phases in the process of integration within the work context. These phases are defined both by the extent to which the individual's actions are directed towards work rather than directed by the disorder. and the nature of the integration struggles engaged in by the individual. Analysis of the case studies reveals two phases that are critical to the process of integration within the work context.

One phase is characterized by those periods in the work life when the individual is overcome by the illness. Thoughts. feelings and actions directed towards work are under represented. The central integration issue in this phase appears to be the individual's realization that an alternate life. one that is directed towards health rather then governed by the illness, is possible. It should be noted that this realization does not necessarily include the acceptance of the diagnosis and treatment. but only awareness that a different and more functional life is within one's control. Winston, for example, experienced both the realization and the acceptance of the disorder simultaneously while Ann and George both had the experience of developing personal resolve to change their situations distinct from their understanding of the disorder.

This realization has been described in the literature on the processes of recovery. Deegan (1988) describes it as a phenomenon that emerges from the individual's growing understanding that other life scenarios are both preferable and possible. However, the

experiences in these case studies are more consistent with those studies that have pointed to a crisis or a significant transition as a trigger for this realization and subsequent actions (Lord, 1991; Rakfeldt & Strauss, 1989). In the cases of Winston and Ann the realization was actually a matter of life or death, while George's experiences were characterized more by major changes in his life situation that pressed for improved functioning.

Work appears to serve the function of providing a meaningful goal orientation for this realization of the self as an active and functional agent. This is not to suggest that individuals are not affected by earlier work and work related experiences, but rather that this realization appears to allow for the consideration of the potential inherent in these earlier experiences. So, Ann's participation in craft activities in the psychiatric hospital provided her with important evidence of her drive for function and George pursued a vocational program that had been previously suggested.

The individual may return to this phase on more than one occasion over the course of the work life. The case study of George, however, provides evidence that recurring episodes of complete loss of control to the disorder may undermine the fortitude for work related efforts. This appears to be the result of several interacting factors. First, the recurrence of the illness was associated with work efforts and subsequently he and his significant others experienced work as the source of his failure. Second, every period of removal from the work realm complicated the process of returning to work (for example, explaining previous terminations and long absences from work, unmanaged disclosure, the problems associated with the older worker looking for work). This threatened George's self-confidence and he perceived the need for considerable skill to negotiate the demands of work re-entry. Finally, there is some suggestion that recurring episodes of the illness may have a cumulative effect with respect to limitations of cognitive

functioning. That is, George experienced that the return to previous levels of cognitive function may take longer with each episode, or previous levels of cognitive function may not be obtained.

A second phase of integration refers to the individual's struggles with the synthesis of the self and the disorder within the work context. The case studies suggest that involvement in work related activities presents the individual with specific tasks related to the process of integration. These tasks are an inherent aspect of working with schizophrenia. They represent both the objective behaviours to accommodate the illness experience within the work environment, and also the subjective experience of creating a sense of the self as a worker with the illness.

The following tasks were revealed from the case study data and represent an initial, if not complete characterization of the struggles inherent in this phase:

- Accepting the diagnosis as true. This includes the understanding that while factors outside of the self may be problematic and interfere with work function, the disorder is also an important factor.
- Engaging in the control of the illness through medical treatments that facilitate work recovery. This task goes beyond the acceptance of psychiatric medications to include collaboration with professionals to arrive at a medication schedule that promotes work function, to reduce and/or negotiate side-effects that compromise work status and to adjust medications in response to emerging symptoms.
- Development of personal awareness of work related interests, goals, aptitudes, skills and resources.
- The development of a strong work identity while simultaneously understanding that specific feelings, thoughts and actions experienced within the work context could be potentially related to the disorder.

- Developing a vigilant attitude towards the early identification of emerging thoughts. feelings and actions that could be potentially related to the disorder.
- Developing an awareness for specific work related features that enhance mental health and well being and those that provoke the illness experience.
- Engaging in active strategies to enhance work function. by capitalizing on personal strengths and resources and compensating for points of vulnerability.
- Developing a balanced attitude that facilitates the interpretation of work related problems within the framework of the universal struggles associated with work.
- Developing a public image in the work environment that is consistent with integration.

The tasks associated with integration represent psychological challenges. They are experienced as conflictual because of the individual's desire to maintain a self view of value and competence that is not easily reconciled within the context of working with a mental illness. In fact the effort put forth towards integration may be on par with the effort put forth to manage the day to day demands of work. The individual's experience of stress may reflect the internal conflicts associated with integration rather than the objective demands of the actual work situation.

Conceptualizing the process of work recovery within an integration framework highlights the problems associated with using cross-sectional perspectives that capture work related status as a measure of functioning and adjustment but do not access key issues that are inherent in the process of work recovery. The concept of work recovery may be a misnomer. implying the stable engagement in work as a culmination of a progression of developments in the work realm. The status of the individual with respect to the tasks of integration may be a better indication of stability of work function. For example George sustained lengthy periods of work participation

and yet was highly vulnerable to loosing his work status because of his ongoing struggles with acceptance of his mental health problems. Similarly, Winston who has been employed for well over a decade in the same job may be viewed from an integration framework as potentially vulnerable to the loss of the worker role because of his inability to reconcile a personally acceptable public image as an employee with a diagnosis of schizophrenia. Ann is perhaps the most stable in the work role having made considerable strides in the tasks of integration.

Two of the case study participants chose to conceal their mental disorder at work. Both individuals expressed concern about the potential response of the work environment, fearing increased scrutiny of their work performance, disapproval and possible job loss. It is noteworthy that neither of these case studies were characterized by actual experiences with disorder related stigma and discrimination within the work realm, although both of these individuals expressed the perception that general public attitudes towards schizophrenia were negative. Their decision to negotiate their work lives without revealing the disorder appeared to be a manifestation of internalized stigma. Lack of disclosure left them vulnerable to being "found out" and to the possible termination of the work situation either through the critical judgements of others or through their own personal difficulties with managing work within this new identity. The tasks associated with integration include the presentation of a public self that is at least consistent with, if not in complete agreement with the personal sense of self. This begs the question: to what extent does the individual's decision to actively veil the mental disorder within the work domain reflect incomplete resolution of the integration issues? Certainly the case studies indicate that there may be series of integration tasks that are specific to the experiences of disclosure and non disclosure.

ii) Evolving nature of the individual's experience of the disorder

Complicating the process of integration, is the fact that the manifestations of the disorder change over time, subsequently impacting on the individuals understanding of the meaning of the disorder within the work context. The processes of recovery as they relate to the changing nature of the disorder itself have been virtually unexplored.

All of the case study participants experienced changes in the nature of the disorder over time. The predominant psychotic symptoms associated with schizophrenia emerged as a primary feature later in the course of the disorder. Subsequently they could reach a point where they had successfully integrated specific features of the disorder within their work lives only to be presented with a new, qualitatively different disorder, requiring further adjustments in work-illness integration.

Further complicating the process of integration is the extent to which individuals receive several different interpretations of the nature of their mental health problems from professionals. This affects their ability to consolidate a consistent perspective on the meaning of the disorder to the self and to the work domain. These changing interpretations can reflect changes in models of the nature of schizophrenia, as in the example of Ann's empowered sense of self in response to interpretations of her mental health problems as a biomedical disorder. They can also reflect changes in the relative priority of services that focus on vocational status in the community services. Similarly all of the participants experienced changing professional interpretations of the nature of their problem. For example, all received several diagnoses over the course of their work lives.

It appears that the individual's participation in the tasks of integration can be uneven. It is possible for an individual to reconcile aspects of integration as they relate to a specific feature of the disorder, but not another feature of the disorder. George understood that the changes in his

activity levels in response to his work schedules impacted on his mental hygiene and he sought treatment quickly. He was not, however, able to understand and respond to emerging psychotic symptoms before they posed a significant threat to his work involvement. It may be that certain patterns of disability are more acceptable to the individual, and perhaps less injurious to the sense of self or that certain features of the schizophrenia are more easily detected as a symptom of the disorder.

iii) Work influences on integration

A key theme arising from the data is that actual involvement in work influences integration. Participation in work has the ability to facilitate or to weaken integration and it appears that these contradictory influences can occur relatively simultaneously within the same individual and within the same work environment. As an example of the negative influence of work participation, George's involvement in work offered him evidence of health and well-being, an apparent contradiction to those images of disability and deterioration engendered by the diagnosis. This weakened his acceptance of the diagnosis and of the need to adhere to medication. Similarly he was faced with the incompatible situation of finding his identity as a worker to be a less attractive self-image than that identity he experiences within the delusions associated with the schizophrenic disorder. Finally, for all of the participants, specific characteristics of the work environment, such as malevolent interpersonal relationships or the lack of clarity of role requirements, undermined the integration by making it difficult for them to distinguish personal problems from environmental characteristics.

As a positive influence on the individual's level of acceptance, involvement in work offers a startling point of comparison between the self as functional and as overwhelmed by the symptoms of the disorder. Working provided Winston with the evidence he required to accept

the diagnosis and medical treatments that lead to his medical and functional stability. The day to day task and social interactions that are an integral aspect of work activities provide an opportunity for self-awareness in relation to social norms for behaviour. So, for example, Ann was able to gain comfort in witnessing strained social interactions as a universal phenomenon in the work place, while simultaneously learning to identify and control her own disorder motivated social behaviours. The desire for and commitment to work provided a context to facilitate acceptance and an active coping stance. Furthermore success and satisfaction in work activities appeared to facilitate integration by providing evidence of personal strengths and abilities and of the potential for the realization of a functional self in spite of the disorder.

4. Internal locus of control, self-esteem and commitment are psychological factors associated with work recovery.

The case studies provide evidence that self-esteem, locus of control and commitment are dynamic psychological factors that evolve over the course of work recovery. These personal resources are required, at least at some basic level, to facilitate the initiation of work related efforts. Once involved in work, the processes and outcomes associated with negotiating work tasks and demands reinforce the individual's self-esteem, sense of agency and commitment within the context of a meaningful goal orientation. This well known process, resembling personal empowerment or the emergence of hopefulness, has been widely described in the literature related to the rehabilitation of people with severe and persistent disorders (see for example, Magill & Vargo, 1977; Kirsh, 1996; Lord, 1991; Lord & Hutchinson, 1993).

The data suggest several distinct personal orientations that contribute to the individuals active and sustained engagement within the work realm. These include: conceptualizing strengths and limitations within a growth framework; maintaining a flexible goal orientation

within the domain of work and; developing strategies to reduce the work disabilities associated with psychosis.

i) Conceptualizing strengths and limitations within a growth framework

Fundamental to success within the work realm was the study participants' growing awareness of personal competencies and limitations in relation to specific features of work. This included awareness of both personal resources (for example Ann's awareness of her attention levels and her comfort in the presence of other people), and social resources (such as her awareness of her family and mental professionals as sources of practical support). This function was an integral aspect of the integration process, and included the recognition of the ongoing and dynamic nature of the illness and that it necessarily impacts on development within work. Difficulties negotiating the internal tasks of integration left the participants highly vulnerable to failure within the work realm. There was a concomitant assault on the psychological factors of self-esteem, sense of agency and commitment.

Interestingly, the case study participants came to understand their strengths and weaknesses primarily while actively engaged in work activities. This facilitated the awareness of the compatibility of personal characteristics and specific environmental features. The three participants highlighted the importance of finding a good match with the work environment. It provided the individual with first hand evidence of very small changes and in particular personal strengths and accomplishments. Even poor matches could be viewed as a learning experience rather than as a failure. This search for the match between the self and work is an important part of the process of work recovery.

It is important to note that the two case study participants who maintain their employed work status, Ann and Winston, had a history of readjusting their involvement in work related

activities that preceded the appearance of schizophrenia. Their prior experiences with matching personal strengths and limitations to the work realm facilitated their ability to actively negotiate the creation of a fit between personal needs and the work environment. In addition this prior experience may have served as a kind of "inoculation" to ease the process of accepting and ultimately integrating the disorder into one's view of a functional self.

ii) Maintaining a flexible goal orientation within the domain of work

The process of work recovery appears to be facilitated by a flexible goal orientation. At the most basic level this represents a focus on work as the goal of recovery efforts, without inordinate constraints imposed by strict standards for achievement or status. So, for example, the case study of Winston demonstrated how the process of work recovery was abetted when his unrealized desire for a career in the human services through university level training was translated into the more achievable goal of college level training in the social services.

This flexible perspective appears to influence work recovery on two levels. First, it provides an accessible path to work. This work represents an adjusted goal but it continues to fulfil valued features of the ideal work goal. Second meeting the challenges and demands of the adjusted path to ultimately obtain work reinforces the sense of the self as competent and encourages the individual to consider the possibility of obtaining the ideal goal in the future. In this manner the idealized work identity is not negated, but only incorporated into a future work view, without compromising the current involvement and growth in work activities. Winston, for example, continues to see his future as including the completion of university level studies.

iii) Developing strategies to reduce the work disability associated with psychosis

The case studies provide vivid descriptions of the transactional nature between the symptoms of schizophrenia and the work context. Each of the case study participants discussed

the necessity of active coping strategies to deal with symptoms at work. They shared the perception that the psychotic symptoms of schizophrenia are particularly threatening because of the intense. unpleasant affect engendered that undermines self-esteem and commitment to work. and threatens the rapid exacerbation of an acute psychotic episode and the subsequent loss of personal agency. Table 6.1 presents a summary of how psychotic disturbances presented within the work context for the three case study participants and the specific strategies they employed to cope with these disturbances. The regulation of psychiatric medications has been excluded as a coping strategy. although it is understood to be a broad based and constant regulatory mechanism.

Table 6.1

Psychosis within the work context and related coping strategies

Symptoms of psychosis within work context	Coping strategies
Winston: Intense affective response to memories induced by low socio-economic districts Rapidly raises anxiety and increases Suspiciousness	Avoid low socio-economic districts. particularly those associated with prior acute episodes of psychosis Select work located in middle class neighbourhoods Counselling to share alternate perspectives on the experience
Ann: Disassociation interferes with learning new tasks and retaining information	Over learning Task analysis and grading Note taking Learning on the job rather than in educational settings
Ann: Frightening visual hallucinations	Self-monitoring techniques

Symptoms of psychosis within work context	Coping strategies
Ann:	
Caustic delusions and auditory hallucinations that interact with workplace to undermine the ability to accurately interpret social situations	Maintaining a detached social stance Relying on neutral interpretations of social situations Use of moral principles to guide behaviours, such as those defined by religious doctrines Counselling to facilitate perspective taking
George:	
Difficulties maintaining relational boundaries that provoke intense affective responses and interfere with critical reasoning, social problem solving and engenders suspiciousness	Counselling to receive assistance with social problem solving Counselling to facilitate perspective taking

The case studies of Ann and Winston reveal that they had considerable work experience prior to their experiences psychosis, but also that they managed this work while they were experiencing considerable psychiatric symptomotology, specifically depressive symptoms. That is, the formal diagnosis of a mental disorder did not represent a rapid decline in the mental health for these two individuals. In Winston's case, he was apparently able to manage these depressive symptoms without the benefit of any formal psychiatric treatments. This early introduction to coping with the transactions between work and symptoms may have provided a period of preparation for the development of attitudes and skills necessary to deal with the complex and disturbing psychotic symptoms within the work context.

5. The individual's perception that valued people believe in his/her potential is associated with work recovery.

Work recovery efforts were supported when valued others genuinely believed in the potential to work and when they conveyed an understanding of the struggles experienced by the individual in the process of work recovery. This is not meant to imply that the significant people in the study participants' support network had insight into the exact nature of the integration issues. Rather they had an appreciation for the difficulties inherent in recovering work function and a respect for the fluctuations that characterized the process. This analysis of the role of social supports in facilitating work recovery is consistent with those expressed by published personal accounts of individuals who have recovered from schizophrenia (Deegan, 1996; 1990; 1988).

The data suggest that people within the support network conveyed their understanding in three distinct ways. Similar to the findings of social support research (Thoits, 1995) these valued people provided important forms of functional assistance through practical aid (i.e. help with transportation, accommodations, subsidizing finances), emotional support (i.e. encouragement, praise, unconditional acceptance) and assistance with coping strategies (i.e. social problem solving, perspective taking). Specific to the work realm, social support facilitated the process of work recovery by providing assistance with securing real work opportunities by accessing a broader social network (for example, George's referral to a community residence), advocating on behalf of the individual (eg. Ann's physician asking that she be considered for a job), or creating work opportunities (eg. public education jobs). The study participants were particularly touched by mental health professionals who they perceived as stepping out of the traditional boundaries of the therapeutic relationship in order to use their influence to secure real work opportunities.

Second, valued people in the social network conveyed their understanding of the difficulties inherent in work recovery by demonstrating a long term commitment to assist the individual through the process. This commitment was characterized by accessibility, flexibility

and a high tolerance for fluctuations in the individual's work related behaviours. In essence, the social support provided the latitude necessary to nurture growth and communicate trust that positive change in the work realm is occurring. There was a recognition that maintaining an attitude of commitment and hope is not an easy task for people within the social support network who are likely facing their own struggles with coming to terms with the meaning of the individual's mental illness. George's case in particularly demonstrates this last point. Although family members remained supportive of George's well being in the community, they became less supportive of his efforts to return to work. This appears to have been a response to their association of work to the exacerbation of his symptoms and the subsequent financial and behavioural crises that ensued.

Finally, the case studies highlighted how the communication of expectations from valued social supports facilitated the process of work recovery. These presented as both expectations that the individual would engage in activities towards autonomy, and self-sufficiency, and activities that would reflect responsibilities or obligations towards others, such as helping out other family members or inspiring others with schizophrenia. Work rehabilitation programs have long been interested in conditions under which expectations actually serve to facilitate productivity levels (Bell & Lysaker, 1996). An important aspect of the expectations in these case studies was the individual's perception that they were real, that is having an actual basis in everyday life and meaningful within the framework of adult role expectations. Furthermore they were considered reasonable with respect to the demands on the individual, without excessive standards for status or achievement.

A surprising finding of the studies was the extent to which disagreeable social relationships can influence work recovery. Each of the case study participants identified at least

one key relationship in the social network that they perceived as antagonistic. It appeared that this relationship served as motivator. exhorting the individual to action in work. The relationships engendered a sense of the need for vindication using the work realm as the proving ground for personal competence and legitimacy. While this relationship promoted work involvement it actually hindered the processes of integration. either by magnifying the threat associated with accepting the illness or by diminishing the individual's sense of the importance and meaningfulness of work related efforts.

6. An integral feature of work recovery is the individual's appraisal of employment as essential to mental health and well being.

The case study data suggest that a particularly potent source of motivation for sustained efforts to meet the challenges and demands of work is the individual's perception that this involvement is fundamental to personal mental health and well being. The mechanisms by which this association between work involvement and mental health occurs in individuals with schizophrenia are complex. The case studies suggest that the mechanisms exert their influence through several distinct but related pathways. These pathways are depicted in Figure 6.1.

Work involvement provides the individual with a context for the integration of the self and the illness experience. While work has received considerable attention as an acceptable vehicle for the expression of the self-identity for persons with schizophrenia (Bebout & Harris, 1995; Lysaker & Bell, 1995), there has been less of a focus on the extent to which it serves as a context for a unified sense of self that reconciles the existence of both health and illness. The task and interpersonal demands of the work situation press for behavioural responses that are consistent with personal and environmental standards. Through the process of experiencing these demands the individual comes to understand and develop aspects of the self such as interests, abilities,

aptitudes and resources. The individual's involvement in work simultaneously provides the opportunity to evaluate the various manifestations of the disorder and to confront the realities of the work-illness interaction.

An important finding of this study is the extent to which this relationship between work and mental health may depend on the individual's level of engagement in the process of integration. Acceptance of the disorder as true appears to be fundamental to the ability to benefit from these features of work that further promote integration. The data suggest that the person who is engaged in the process of integration is perhaps more likely to maintain a balanced perspective that tempers the meanings of the struggles of working. So, for example, Ann's case demonstrated that job changes or tensions with a supervisor can be understood as promoting growth and positive change. Without this basic level of acceptance the individual maintains a view of the self that cannot accommodate the illness experience within the work environment and subsequently is at risk for evaluating work as personally threatening and for a sense of failure and defeat in the wake of the inevitable struggles.

In the process of negotiating work demands the individual has the opportunity to experience the various benefits that underlie the positive meanings associated with work. These benefits appear to serve as powerful reinforcers that encourage the individual's continued efforts to succeed at work. The case study data suggest three routes through which these reinforcers exert their influence. First, they appeared to directly decrease the intensity of the psychotic symptoms, specifically by providing structure and routine and by distracting the individual away from the symptoms. Winston's case provides the most obvious example of this phenomenon, given the fact that he experienced this as a benefit of employment but a particularly problematic feature of his underemployment.

Second the positive experiences associated with work had a positive influence on the individual's self-esteem and sense of personal agency and control and subsequently encouraged the desire to actively engage in strategies to identify and control emerging psychotic symptoms. Furthermore this rise in self-esteem and agency averted other disturbances in mental health. specifically depression and anxiety. The case study data suggest that lessening the symptoms of depression and anxiety leads to an accompanying reduction in the intensity of psychotic symptoms of the illness.

Finally. the individuals involvement also lead to positive changes beyond the person-work interaction. It lead to improvements in family relationships (Ann) and social relationships (George). In Winston's situation his participation in work related activity was considered so unique that he received the attention of the media. These changes subsequently provided an alternate route to the enhancement of self-esteem and sense of personal control.

These findings are in keeping with investigations that have highlighted that the recovery process is mediated by the meanings that individuals with schizophrenia attach to the struggles and strains of daily life. and by the personal significance of even objectively small changes or accomplishments in social functioning (Davidson. 1994; Davidson & Strauss. 1995; 1992; Strauss. 1992: Lysaker & Bell, 1994). Previous research by Arns and Linney (1993) has linked participation in work to improvements in self-esteem and quality of life. These investigators suggested that it was the relative work status (i.e. unemployed to employed) that mediated self-esteem. However these case studies suggest that while this change in work status is a critical point. particularly in overcoming the state of lethargy and inertia following periods of reconstitution from acute episodes of the illness, the improvements inherent in work recovery operate on an ongoing basis.

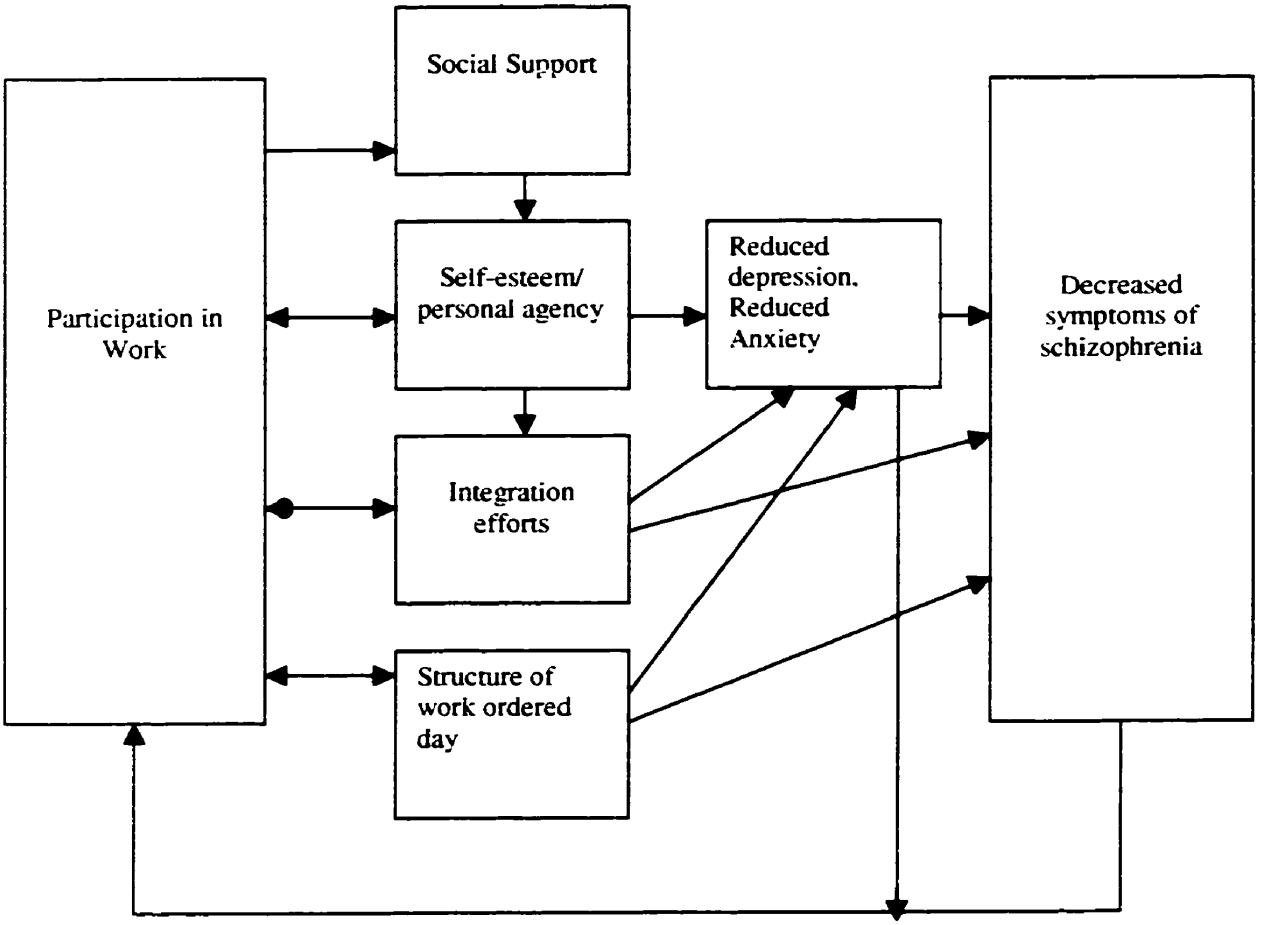

Figure 6.1

Influence of Work Participation on Mental Health

Summary

Chapter 6 has presented a cross case analysis focusing on the development of the understanding of work recovery in schizophrenia based on the transaction between the emerging data and extant theory. The following section summarizes major findings of the study:

1. **Work recovery is best understood from a life course perspective.**

The study findings support the value of a life course perspective for understanding the process of work recovery. Specifically the life course perspective lead to the identification of four distinct but interrelated longitudinal patterns. These patterns and their specific features are summarized in Table 6.2.

Table 6.2

Longitudinal Patterns of Work Recovery

Patterns	Specific features
The centrality of work	Involvement in purposeful activities Efforts to construct a vocational direction Occasional paid work
The coexistence of work and schizophrenia	Work function with refractory symptoms as the norm
Non-linear pattern of career mobility	Progressive achievements within the work realm
Transactional nature of person-work-environment relationship	Positive achievement reinforces work related efforts by promoting self-esteem directly and by eliciting support of significant others

Patterns	Specific features
	Changes in work environment influence individual's work status
	Changing social attitudes influence individual's work status
	Engagement in a variety of work situations is beneficial to work recovery if understood from a learning framework.

2. Positive meanings attached to the worker role facilitate the individual's ability to negotiate the stresses associated with the worker role.

The study supported the theoretical proposition that individuals with schizophrenia attach personal meanings to the worker role that influence their ability to sustain the direction and commitment necessary to negotiate the stresses and strains associated with employment. While these personal meanings were similar to those of the general population the case studies highlighted that specific meanings are both highly individual and specific to the experience of working with schizophrenia.

Table 6.3 summarizes the five distinct positive meanings that emerged from the data:

Table 6.3

Positive Meanings Associated with Work

Meaning	Features
Realization of values and goals	Fulfilment of earlier vocational expectations Construction of a meaningful life A corrective experience for previous social marginalization Fulfilment of family values
Social reciprocity	Work interactions marked by reciprocity, equality collegiality and affection Meaningful contribution within the work context Financial societal contribution Inspiration to others affected by mental illness
Identity validation	Legitimate self-identity Transformation of social relationships Possible gender based variations
Framework for daily life	Daily structure Involvement in goal directed activities Approximates temporal rhythms of broader community
Earning a living	Access to resources Low incomes necessitate alternate financial resources

In addition, the study revealed several negative meanings associated with employment that interfere with sustained commitment and work directed behaviours. These are summarized in Table 6.4.

Table 6.4

Negative Meanings Associated with Work

Meaning	Features
Real or perceived threat of failure	Reinforces sense of inadequacy Contributes to internalized stigma
False sense of mental health	Denial of illness and subsequent lack of adherence to psychiatric treatments
Association of work with exacerbation of symptoms	Significant others perceive work as threat to individuals well being and to the stability of their relationship the individual
	Disability pensions unable to efficiently respond to individual's changing financial needs
	The challenge of explaining unusual behaviours on the job

3. A central feature of work recovery is the perception that it is possible to create a functional self-identity from the disorder.

Rather than the development of a functional self-identity separate from the disorder these studies suggest that a central task of work recovery is the integration of the person and the illness within the work context. Three distinct but interrelated components of integration emerged from the case studies. These are summarized in Table 6.5.

Table 6.5

The Components of Integration

Components	Features
Two phases of integration:	
a. Realization that a life not governed by the illness is possible	Crisis or significant transition as trigger for realization
	Work as goal orientation for the realization of functional self
	Recurring episodes of loss of control to illness undermines fortitude for work related efforts
b. Synthesis of self and disorder within work context	Nine tasks associated with synthesis Synthesis as psychological challenges that are stressful for the individual Integration as a measure of work recovery
Evolving nature of the individual's experience of the disorder	Manifestations of the illness change over time
	Professional interpretation of the illness change over time
	Uneven participation in the tasks of integration
Work influences on integration	Participation in work plays a central role in integration

4. **Internal locus of control, self-esteem and commitment are psychological factors associated with work recovery.**

The case study provides evidence that these psychological factors evolve over the course of work recovery. While they appear to be required at some basic level to initiate work efforts. they are reinforced through actual work participation. Three distinct personal orientations that facilitate the individual's engagement in work efforts were revealed: i) conceptualizing strengths and limitations within a growth framework; ii) a flexible goal orientation within the work domain. and: iii) the development of strategies to reduce the work disability associated with psychosis.

5. **The individual's perception that valued people believe in his/her potential is associated with work recovery.**

The study provided evidence for the theoretical proposition while contributing additional information about the specific features of social supports that are enabling of the process of work recovery. Specifically the social supports conveyed their belief in the individual by:

- providing practical assistance in the form of resources that supported work efforts;
- offering emotional support and positive reinforcement for work related efforts
- providing assistance with developing coping strategies for specific work situations
- securing and creating real work opportunities
- advocating on behalf of the individual in the work domain
- developing access to broad social networks
- making a long term commitment to the individual characterized by accessibility, flexibility and a high tolerance for fluctuations in work related behaviours
- the expectation of efforts directed towards autonomy and self-sufficiency

6. **An integral feature of work recovery is the individual's appraisal of employment as essential to mental health and well being.**

The case studies supported this theoretical proposition. An initial model demonstrating the mechanisms by which work participation appears to influence mental health and well being was developed from the case study data.

CHAPTER 7

DISCUSSION

Introduction

This study presents important insights into the processes by which people with schizophrenia recover involvement in the work domain. While my case analyses support many aspects of the theoretical propositions, they also advance the development of a coherent model of work recovery by: 1) demonstrating the application of the theoretical propositions to the work domain; 2) developing aspects of work recovery that are not adequately represented in general conceptualizations of recovery, and; 3) providing insights into the individual's subjective experiences with reconstituting a work life.

In this the final chapter I will address key findings of the study in relation to extant theory and the related literature. The chapter will conclude the thesis with a discussion of the implications for future research.

The Synthesis of Recovery Theory and the Illness Experience

A particularly important finding of this study is the extent to which the extant recovery theory fails to address the illness experience as an integral aspect of the individual's participation in work. Only one of the six theoretical propositions, related to the understanding of the self as separate from the mental disorder, focuses directly on the individual as a person diagnosed with schizophrenia. In fact it can be argued that, for the most part, these propositions are applicable to the general population.

The tendency for psychiatric rehabilitation approaches to inadequately address the role of the mental disorder in conceptualizations of social improvement has been noted in the literature (Strauss, 1986; Davidson & Strauss, 1995). Psychiatric rehabilitation specialists may have under

emphasized the illness experience in an effort to differentiate their professional domain from biomedical models. It may also be that the ascension of recovery theory represents an attempt within the psychiatric rehabilitation field to redress traditional paradigms that have approached the social functioning of individuals with schizophrenia as a primarily clinical dilemma. Whatever the reason, this study indicates that there is much to be gained from incorporating schizophrenia into theories about recovery in general, and work recovery specifically.

This apparent separation of the individual into distinct compartments of function and disorder is problematic on many levels. First it interferes with our ability to understand and then to accurately convey the experience of the individual as he/she negotiates the work domain as a person with schizophrenia. Second, it interferes with our ability to understand the nature of the challenges that face the individual within the work domain. This applies both to our understanding of objective performance in the work realm and of the subjective, psychoemotional issues that the individual must reconcile. Finally, it interferes with our ability to conceptualize how participation in work can facilitate the individual's mental health and well being.

Work as the praxis of recovery

This study suggests that work represents a social expression of the individual's attempts to define a functional self-identity. Participation in work provides the opportunity for self-discovery and confirmation of personal strengths and limitations. It plays a central role in the acceptance of the mental disorder and the understanding of the relationship of the disorder to the self within the context of real work situations. As a demonstration of personal responsibility through pro-social behaviour, work involvement can engage a social network in a broad spectrum of emotional and practical support behaviours.

The level of work function reached by the individuals in these case studies is assumed to be exceptionally high for the population affected by schizophrenia. It is important to note that their participation in work occurred quite close, temporally, to their awareness of themselves as active agents on behalf of their own well being. The importance of action in the domain of work has been recognized as an integral aspect of the development and the actualization of the functional self (Kirsh, 1996). Lysaker and Bell (1995) and Babout and Harris (1995) suggest that the actual experience of working is necessary if the nucleus of the worker identity is to be fostered.

In general, speculations about recovery have suggested that a phase of coming to terms with the disorder, self-awareness and self redefinition are precursors to involvement in complex social roles such as work. For example, Davidson and Strauss' (1992) qualitative study of the processes of recovery from severe psychiatric disorder highlight the appraisal of one's resources primarily as a precursor to action. The participants in their studies appear to have been at a very basic phase of recuperation from episodes of severe psychiatric disorder and this may reflect the need for some individuals who are initially embarking on the path of recovery to accent any evidence of competence to facilitate action.

Young and Ensing's (1999) grounded theory analysis attempts to elucidate the components underlying the recovery process. They placed vocationally related activities in the middle to late stage of recovery, implying that work represents higher order functioning that follows considerable activities of self awareness and basic functioning. Unfortunately the definitions of recovery in this study are vague precluding any meaningful evaluation of the study findings. The eighteen participants are only described as "... people with psychiatric disabilities who had a variety of recovery experiences" (Young and Ensign, 1999, p. 222). Furthermore, the

study questions were generally related to the participants' experiences with recovery and subsequently may not have proved sensitive enough to capture the interrelationship between work and the subjective processes of acceptance and self-discovery.

My analyses suggest several factors that might contribute to the absence of a prolonged period of pre-vocational activity. These factors include a strong work ethic, the expectation of work participation by significant others, practical and emotional support for work related activities, and a flexible attitude towards acceptable work. Perhaps most notable was the proactive role of family members and mental health professionals in assisting the individuals to secure employment.

Integration

An important finding of my analyses is that a central struggle of the individual with schizophrenia is the integration of the disorder with a functional sense of self in the work realm. This is inconsistent with recovery related studies that have suggested that a primary struggle of recovery is the recognition of a functional sense of self, separate from the disorder. The distinction here is far more meaningful than a subtle variation in language. The concept of integration presented in this thesis appear to be closely related to Pettie and Triolo's (1999) description of the "perceptual transformation" (p.260) of the self-identity that accomodates the illness experience. The emergence of integration as an integral task of work recovery suggests that speculations about recovery have underestimated the influence of the illness experience (much like my own stated biases on entering the study) without conceding to biomedical interpretations of the person-illness relationship.

Although the tasks of integration are conceptualized as primarily psychoemotional, the nature of these tasks are given meaning through participation in work. For the outside observer,

the individual's objective behaviours in the work realm provide an opportunity to witness the struggles inherent in integration but they do not reveal the meaning of these struggles. The case studies support the proposition that positive meanings associated with the worker role facilitate the individual's motivation to meet the demands of employment. Beyond this they suggest that these meanings are highly significant to the individual's personal sense of identity. These personal meanings must be considered in order to understand the individual's subjective and objective responses to the struggles associated with work.

Reconciling the juxtaposition of the illness and the person in the recovery process has proven to be quite elusive in recovery related literature. It may be that addressing recovery as an abstraction from the day to day struggles of life interferes with our ability to conceive the evolution of a self-identity that incorporates both health and illness. If this is the case, then developing an understanding of recovery within the context of individuals' involvement in social roles, such as work, may prove to be the approach of choice. These three case studies, for example, provide specific examples of the psychological tasks that individuals must negotiate in the work realm. Notable research efforts that have used clinical vignettes, case studies and personal stories to uncover the convergence of illness and person in daily life include studies by Lysaker and Bell (1995), Babout and Harris (1995) Davidson and Strauss (1995) and Pettie and Triolo (1999).

Career Trajectory

An important aspect of my study is the development of the concept of career trajectory as a framework for integrating the work experiences of the individual over the life course. Cross sectional frameworks constrain our understanding of the individual's work life to the here and now or, at best, to overly simplistic interpretations of the course of work recovery. The

framework of career trajectory facilitates our ability to recognize subtle accomplishments, to reconceptualize losses in the work realm as active self-learning and to appreciate the ongoing influences of a broad spectrum of activities throughout the work life. As such it may prove to be a particularly empowering perspective in clinical situations to counteract the pessimism and despair that can engulf both individuals with schizophrenia and their clinicians when considering work related issues.

In addition, it is a particularly important perspective to consider in the development of outcome measurements and evaluation protocols. With their typical focus on objective criteria and on time limited outcomes, these evaluations are unable to account for the possibility that an individual's engagement in a service today may have a profound influence on an participation in employment many years later.

Thoits (1994) has argued that research on people in social roles, such as work, has failed to appreciate the extent to which changes in vocational status are characteristic of the work lives of the general population. She argues that these changes reflect both learning and growth in that they represent our efforts to actively maintain our health, functional identities and our self-esteem.

Person-Work-Environment Transaction

Consistent with conceptual models that emphasize the transactional relationship between the individual and the environment (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996), these case studies facilitate an examination of the multiple processes that elicit growth and change in the work domain over the course of time. A person-work-environment perspective assumes that features of the person and the environmental context of work interact to shape work performance

This interaction is evolutionary, and as demonstrated within the case analyses work participation is shaped by the ongoing changes at the level of the person and the environment.

There has been an absence of research that addresses the ongoing and dynamic nature of the individual-environment relationship and how this influences work recovery. Notable exceptions include Strong's (1995) ethnographic study of the experiences of mental health consumers within affirmative businesses, and Strauss and colleagues' (1985; 1988) longitudinal studies of the evolution recovery processes within the context of individual-environmental interactions.

In addition, speculations about recovery have tended to focus primarily on the individual. Studies have attempted to uncover the environmental characteristics that facilitate the work performance of individuals with psychiatric disorders (Kirsh, 1996; Akabus, 1994). However, my analyses suggest that it is important to focus on the manner in which environmental features interact with the individual's experiences with schizophrenia to influence performance and well being in the work realm.

An environmental issue that arises as a particular barrier to employment in these case studies is the extent to which individuals with schizophrenia experience limited incomes and financial insecurity when they attempt to constitute a work life. My analyses reveal that a combination of several factors contributes to this bleak economic situation, including low paying jobs, limitations in the number of hours worked, medication costs, pension disincentives to work and inefficiencies in the administration of pensions. These factors have been identified in a number of studies focusing on the financial aspects of working with a significant psychiatric disorder (Noble, 1998; Polak & Warner, 1996 Warner & Polak, 1995). Certainly one of the most prevalent features of those case study participants who have sustained their work involvement is

the extent to which alternate sources of financial support leave them relatively free from these economic disincentives.

Work Foundations

The career history data present an interesting possibility for understanding the inclination that some individuals demonstrate towards tenacity and effectiveness in coping actively with the challenges of the work-illness interaction. Research studies have consistently demonstrated a positive relationship between early work experience and work function in schizophrenia. This has typically been explained as the benefit of well developed work values, and knowledge and experience with work attitudes and behaviours (Anthony & Jansen, 1984; Beiser, Bean, Erickson, Zhang, Iacono & Rector, 1994). These interpretations have been based on the assumption that pre-illness status is that of a healthy and socially adjusted individual.

These case studies have suggested that an important consideration of the pre-illness work experience is the extent to which those individuals who met the criteria for work recovery had successfully negotiated significant psychiatric symptomotology without a formal diagnosis or psychiatric interventions. This early experience of coping with features of mental disorder within the work context may have provided a period of preparation and the skills necessary to manage work with complex and disturbing psychotic symptoms. Similarly, it may have introduced individuals to the psychological tasks of integration. It is possible that these tasks may have been more palatable when encountered without the burden of the stigmatizing label of schizophrenia.

Schizophrenia and Work Disability

The potential for individuals with schizophrenia to actively control the symptoms associated with the illness has received much attention in the mental health literature (see for

example Brier & Strauss, 1983; Hatfield, 1989; Harding, Zubin & Strauss, 1992). Strauss (1989) has referred to this as a broad phenomenon encompassing a wide range of "regulatory mechanisms" whereby the individual "...consciously or unconsciously-often appears to adjust perceptions, interpretations, and actions to maintain a certain level of self-esteem, structure, involvement with world, social contact, or analogous goals" (p.184). To date most research efforts in this area have focused on the individual's efforts to cope with distinct and isolated symptoms (Carr, 1988). More recently there have been attempts to understand and differentiate the experience of symptoms and coping strategies within the real life context (Wiedl, 1992, Van Den Bosch, Van Asma, Rombouts & Louwerens, 1992). Lysaker & Bell (1993) stress that while there has been an assumed association between the impairments of schizophrenia and work function, there is a general paucity of research examining the specific nature of work disability in schizophrenia.

This research study supports the idea that the psychotic features of schizophenia are particularly difficult to manage within the work context because of their ability to engender intense negative affective responses towards benign events and to undermine the interpretation of complicated social situations.

Conclusion: Implications for future research

The case analyses offer several possibilities for the direction of future research. For example:

- This study has provided new insights into the role that early work experiences may play in the vocational outcomes. The suggestion that individuals may negotiate the worker role with psychiatric symptoms before formal diagnosis and treatment requires further research.

- This study has provided only an initial perspective on the struggles inherent in integrating the self and the disorder within the context of work. Future studies should address the tasks of integration in work recovery and the factors that are likely to promote the reconciliation of integration issues. The issue of disclosure of the illness on the job requires further consideration, both with respect to its relationship to integration and the manner in which individual's negotiate their self-identities within the context of both disclosure and non-disclosure.
- This study offers a conceptual framework for understanding the mechanisms by which work participation improves mental health and well being in schizophrenia that requires further empirical investigation.
- Future studies should address the extent of financial underemployment of individuals with schizophrenia and the influence of this economic hardship on the course of work recovery. The processes by which individuals with schizophrenia come to be recipients of disability pensions also requires closer examination. Certainly this study suggests the need to explore the factors that lead professionals to recommend disability pensions and the impact of this economic status both on the individual's self-identity and on family relationships.
- The nature of the work-illness interaction requires further investigation. There appears to be a need for investigations specifically addressing the manner in which psychosis presents as a work disability.
- Further research investigating the coping strategies used by individuals with schizophrenia within the context of work is required.

Certainly increasing the number of case studies focusing on work recovery could only strengthen our understanding of the processes of work recovery in schizophrenia. However the

practical and resource issues related to the case study methodology are daunting and the possibility of further gains relative to the expenses of this design require serious consideration (Sechrest, Stewart, & Sidani, 1996). This study has espoused the benefits of approaching theory development in the area of work recovery from a life course perspective using qualitative methodologies that are grounded in the experience of the individual with schizophrenia. Grounded theory may prove to be a practical yet powerful approach for furthering the conceptual development of work recovery.

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APPENDIX A

INFORMATION SHEET

WHAT FACTORS HELP OR HINDER PEOPLE WITH SCHIZOPHRENIA IN RETURNING TO WORK?

This is the central question of a research study to be completed by Terry Krupa a PhD student at the University of Toronto. Terry is looking for individuals who have been diagnosed with schizophrenia, and are between the ages of 30 and 45, who would be interested in participating in this study.

Here are a few details that may help you decide if you would like to participate:

- **Participating in the study will not cost anything. Any expenses, such as travel expenses, will be covered by the research project.**
- **Terry will attempt to get an in-depth picture of each participant's experiences with returning to work.**
- **The meetings for this study will take place in a private location.**
- **All of the information collected during the study will be kept confidential.**
- **Participants can withdraw from the study at any time.**

If you would like more information about this study or if you are interested in participating in this study please call:

Terry Krupa
(613) 533-6236

APPENDIX B

INFORMED CONSENT FORM

Title of Project: Work Recovery in Schizophrenia

Researcher: Terry Krupa, Doctoral student at the Ontario Institute for Studies in Education/University of Toronto

What is the study about?

You are being asked to participate in a research project. The purpose of this project is to increase our understanding of the factors that help people who have been diagnosed with schizophrenia to return to work. The project is being completed by Terry Krupa, a graduate student, to meet the thesis requirements of doctoral level studies.

What's involved?

If you agree to participate in this study you will meet with the researcher, Terry Krupa, for several interviews to discuss your experiences in returning to work. You will be asked to meet with the researcher on six or seven occasions. You may choose the location of the interviews to ensure your comfort, but the location should be quiet and private. Each of these meetings will take about one hour. These interviews will be tape recorded. In order to get a complete picture of the factors that influence return to work you will also be asked to allow the researcher to have access to your hospital or mental health service records. The relevant legal consent forms will be completed with you before the researcher accesses these records.

You are also being asked to grant permission to interview other people who have additional information about your work life. These will only be people that you select.

Participation in the study should not cost you anything. The researcher will schedule the meetings so that they do not interfere with your work or other important daily life events. You will be given the money to cover any travel costs that you may incur. Also a cold or hot drink will be available to make you more comfortable during the interview. You will be offered $80.00 for your participation in this study. This is a small amount of money to recognize the time and effort you put in to help complete the study.

What are the benefits?

You may not benefit directly from this study. What is learned from the study may help in the development of approaches to increase the likelihood that people who have been diagnosed with schizophrenia are able to return to work. Some people enjoy the opportunity to share their experiences.

What are the risks?

No risks are expected from this study. Some people feel nervous at the beginning of interviews. If you feel uncomfortable during the interviews please let the researcher know. You can take a break, or meet at another time. You can decide to end your participation in this study at any time. If there is any question you do not wish to answer, just tell the researcher to skip it.

Will I learn anything about the outcome of the study?

The researcher will provide you with a rough draft of writing where your information is featured. You will be asked to review this material. If you like, the researcher will provide you with a copy of the final written report and explain the outcome and conclusions to you.

What about confidentiality?

All of the information obtained during the course of this study is strictly confidential. You will be referred to by your first name only during interviews and by a pseudonym rather than your personal name on any written information, including the final report. All of the written and tape recorded information will be stored in locked filing cabinets. Only the researcher, a typist, the thesis supervisor and committee will have access to your information. Any research reports that come from this study will not identify you.

Is my participation voluntary?

It is your decision if you want to take part in this study. You can change your mind about participating at any time. This will in no way affect any services you receive. You may also request, at any time, to withdraw from this study. If you withdraw, all information about you collected by the investigator will be destroyed.

Participation statement

Terry Krupa has read the above information to me. I understand what is involved in the study. My questions have all been answered. I have had enough time to think about whether I want to take part. I am signing this form voluntarily. I know that I can change my mind and not take part at any time. I will still receive the best care available. If I have any more questions I will call:

Terry Krupa at (613) 533-6236

If I am still concerned about the study I will call:

Dr. Carol Musselman, Thesis supervisor, at (416) 923-6641

By signing this consent form I am showing that I agree to take part in this study. I have a copy of this form that I can keep.

Signature of participant | Date

Name of participant (please print)

I have carefully explained to this person the nature of the research study. I certify that, to the best of my knowledge, the person understands clearly the nature of the study, the demands, the benefits and the risks involved to study participants.

Signature of researcher | Date

APPENDIX C

Predicted and rival explanations for work recovery in schizophrenia

Predicted explanations (Theoretical propositions)	Rival explanations
Work recovery is best understood from a life course perspective.	Work recovery is related to the natural evolution of the disorder.
Positive meanings attached to the worker role facilitate the individual's ability to negotiate the stresses associated with work.	The individual who experiences work recovery has a mild form of the disorder.
A central feature of work recovery is the individual's perception that it is possible to create a functional self-identity separate from the disorder.	Work recovery is related to a later age of onset of schizophrenia.
Internal locus of control. self-esteem and commitment are psychological benefits associated with work recovery.	Low demand jobs are associated with recovery in schizophrenia.
The individual's perception that valued people believe in their potential is a central feature of work recovery.	Short periods of unemployment are associated with work recovery.
Individuals with schizophrenia who are employed appraise work as essential to their health and well being.	