

The Process People with Schizophrenia or Schizoaffective Disorder Use to Return to or
Initially Secure Employment after Diagnosis

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This dissertation titled
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Initially Secure Employment after Diagnosis

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ABSTRACT

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The Process People with Schizophrenia or Schizoaffective Disorder Use to Return to or Initially Secure Employment after Diagnosis (184 pp.)

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Research indicates that people with schizophrenia or schizoaffective disorder have a high rate of unemployment. This qualitative phenomenological study was designed to explore the perceptions of eight individuals with either disorder who have secured employment after diagnosis. The rationale for this study arises from the researcher's desire to find the process which was used by individuals with either disorder to become employed. It was the researcher's assumption that uncovering such a process could lead to implementation of employment as a therapeutic goal of treatment with such individuals.

The purposefully selected sample consisted of eight individuals from a Midwestern state who have been diagnosed with either disorder. The primary method of data collection was three in-depth interviews. The data were organized according to the research and field-developed questions asked of participants. Analysis and interpretation of findings were completed using the van Kaam method of qualitative data processing. The research revealed that participants in the study interpreted recovery as living in as much of a perceived degree of normalcy as possible. Recovery was found to be a developmental concept among participants. The six following categories were developed from the data: self-help; employment; assistance with employment; benefits of

employment; functioning at a perceived normal level while living as full a life as possible with the illness; and recovery to employment. Five themes were found: self-care; supports; issues of employment; rewards of employment; and recovery process. Fourteen sub-themes emerged from the analysis of data. They were as follows: medication compliance; stress reduction; approaching employment gradually and carefully; stigma; disclosure of condition; formal accommodations; change of employers due to problems of disability; lack of failure; family and friends; governmental support; private supports; intrinsic rewards of employment; extrinsic rewards of employment; developmental process; and normalcy.

Recommendations are offered for mental health and rehabilitation professionals who work with this population and for further research possibilities. Given that multiple factors are present in an individual's recovery to the point of employment with either disorder, the recommendations suggested should be considered on an individual basis.

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CHAPTER 1: INTRODUCTION

I sought to investigate how people with schizophrenia or schizoaffective disorder secure and maintain employment. In this population, unemployment rates of 57% to 97% have been reported (Banks, Pandiana, Simon, and Tracy, 2003; Geertsens, Davis, and Ellis, 2002; Mowbray, Moxley, and Jasper, 1997). With such high unemployment among this group, it is plausible to investigate the processes that those who have gained and maintained employment found beneficial.

Mental illnesses of all types carry a certain amount of stigma. Research indicates that schizophrenia carries some of the most profound stigma (Lauber, Carlos, and Wulff, 2005). When people are affected with this disorder, it is difficult to find and maintain employment. The prognosis for this disorder has been bleak for many years. Only within the past 40 years has a more optimistic prognosis begun to be accepted by some professionals and people with this disorder (Strauss, 2008).

This qualitative study analyzed processes used by people with schizophrenia or schizoaffective disorder returning to employment after an absence because of their illness, or people who have obtained employment for the first time after suffering from the onset and progression of these disorders. The intent was to determine commonalities among such people.

Background

The number of people with schizophrenia or schizoaffective disorder is estimated at 1.1% of the total population of the United States: approximately 3.2 million people using 2005 data, with world prevalence rates estimated to be 51 million people at any one

time (Wyatt, 2005). These illnesses can be devastating; according to *The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (American Psychiatric Association [APA], 2000), 10% of the affected population complete suicide at some time after diagnosis. The social stigma which comes with any mental illness is most prevalent with these particular disorders (Lauber, Carlos, and Wullf, 2005).

The prognosis for people with schizophrenia or schizoaffective disorder has been historically bleak, beginning with the analyses of the psychiatrists Kraepelin and Blueier in the 19th century (Strauss, 2008). In recent years, the advent of atypical antipsychotics such as clozapine, in combination with psychosocial treatment, has led to a more positive outlook for people with this disorder. Longitudinal studies are beginning to alter negative prognostic perceptions long held by many mental health professionals and laypeople (Krupa, 2004).

Many people with these illnesses have an unstable work history. The cost to U.S. society of the 26.2 million people with schizophrenia, schizoaffective disorder, major depression, and anxiety disorders has been estimated by the National Institute of Mental Health (NIMH) as being \$44 billion in lost time from work for those afflicted and their caregivers (NIMH, 2005). Included in that estimate are the costs of social services and criminal justice resources. The personal, nonmonetary cost to the individual in lost dreams and lowered self-esteem is immeasurable (Kruger, 2000).

Like many Americans, people with schizophrenia or schizoaffective disorder view work as a significant part of a normal life (Becker and Drake, 1994). However, many people with these disorders are not a part of the world of work (Ahrens, Frey, and Burke,

1999). The reasons for this have been speculated on and researched at length, with differing conclusions (Andresen, Oades, and Caputi, 2003; Becker and Drake, 1994; Kruger, 2000; Olsheski and Schelat, 2003).

Some researchers have suggested that factors such as societal stigma impact employability of such individuals negatively (Kruger, 2000). Others have speculated that individuals with either disorder have not developmentally progressed through the recovery stages of such illnesses (Andresen, Oades, and Caputi, 2003) and are not at the level of recovery that employment can be considered as a possibility. Becker and Drake (1994) speculated on the symptomology of either illness precluding employment with some individuals. Employment of individuals with mental illness has been addressed in recent history by the signing into law of the Americans with Disabilities Act of the United States (Olsheski and Shelat, 2003). Although this law addresses all individuals with a disability, this was a significant step forward for people who are psychiatrically disabled (Olsheski and Schelat, 2003). Olsheski and Schelat (2003) have determined that the Americans With Disabilities Act of 1990 was possibly not as effective as was first hoped. A detailed description of this law is included in Chapter 2.

Considering the impact of schizophrenia and schizoaffective disorder on both society and the individual, it may be beneficial to investigate what employed individuals with schizophrenia or schizoaffective disorder found helpful in gaining and maintaining their employment. This study looked for common factors and differences in these individuals, using a qualitative research design of phenomenology. In-depth interviewing was used as the method for gathering data. This type of interviewing gave a voice to

individuals with schizophrenia or schizoaffective disorder and captured a richness of detail that is lacking in the existing literature. Although some qualitative studies exist which focus on the recovery of people with either disorder (e.g., Andresen et al., 2003), none have focused exclusively on employment after diagnosis and none have given a voice to such individuals.

Qualitative analysis was chosen since it allows for a full and thick description of a phenomenon.

A thick description does more than record what a person is doing. It goes beyond fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard (Denzin, 1989, p. 83).

Phenomenology as a philosophy was first described by the German philosopher Edmund Husserl (1859–1938) (Cohen, Kahn, and Steeves, 2000). His basic assumption was that we can only know what we experience through our senses and our conscious awareness and that “subjective experience incorporates the objective thing and a person’s reality” (Patton, 1990, p. 69).

A phenomenological design was suited to this study for at least three reasons. First, it is a qualitative study rather than a quantitative study because of the individual differences that existed in any process used by the respondents. This was determined most effectively through in-depth interviewing. Second, the study included eight people who shared a wealth of practical experiential data of the phenomenon of returning to employment after diagnosis. This number of respondents is consistent with previous

phenomenological studies and sampling theory for such studies (Creswell, 1998; Luborsky and Rubinstein, 1995; Morse, 1994). The analysis of individual experiences led to the discovery of the essence of this phenomenon. Finally, the phenomenological approach of data analysis was most appropriate because of the use of *epoche*, which is the process of analysis whereby the researcher sets aside preconceived notions, judgments, and interpretations of the experience studied (Patton, 1990). This was accomplished by first recognizing and then setting aside prejudices and predispositions and allowing the sensory-perceived world to enter the consciousness anew and to perceive it as if for the first time. The researcher bias in this study was first listed, analyzed, and then controlled as much as possible. I accomplished this through a thorough analysis of the prejudices and preconceived notions I had regarding mental illness in general, as well as the employment of individuals with a mental illness.

Researcher Bias

I am a 49-year-old White man who was born and grew up in southeastern Ohio. I was the third child and second son of four children born to my parents, who were also born and raised in southeastern Ohio. My parents both worked while I was growing up, as did both sets of grandparents. I was raised in the Protestant faith until my teen years, when I attended the Catholic Church in my hometown. My early years were spent attending school and working on the family farm. I believe I developed a strong work ethic because of the modeling of all the adults in my family. I further believe that this ethic was passed down culturally from my ancestors. At the age of 15, I began working at an auto salvage yard as an auto detailer. That was my first real job for steady wages.

From that point until I turned 33 years of age, I worked in some capacity in the private sector. I had various jobs over those years, but my tenure was never longer than two years. At the age of 33, I was no longer able to work because of an illness that had progressed undiagnosed and untreated since my teen years. The illness is schizoaffective disorder.

At the age of 30, I was first hospitalized for mental illness while living in southern California. The first diagnosis I was given was “psychotic episode.” My first psychiatrist was somewhat optimistic when he told me I might not have any further episodes. I partially recovered after three months and returned to employment in a retail warehouse. I was able to work there for six months before my illness made it impossible for me to continue. I then moved back to Ohio and did various short jobs for people, such as painting houses and cutting firewood. I was not taking medication for my illness during this time and was continually bothered by my thought and emotional disorders.

In 1993, I had the worst psychotic episode of my life and was hospitalized for three months in a state psychiatric facility. My diagnosis was changed to paranoid schizophrenia. I was sent home with a bag of medication and told that I would most likely have to continue taking medication for my mental illness the rest of my life.

I applied for Social Security disability in 1994 with reluctance, feeling guilty because I could not hold down a job long enough to support myself. My claim was approved. I spent the next three years trying various medications prescribed by my psychiatrist to control my symptoms. It was not until I had another slight episode in the spring of 1997 that my new psychiatrist at the time changed my diagnosis to

schizoaffective disorder and changed my medication. I have been on a similar medication cocktail since 1997 and have had only slight symptoms since.

My higher education began in 1983 at a small community college in southeastern Ohio and continued until 1989, when I graduated from a state college in California. In 1998, after my illness was under control, I applied to and was accepted in the master's program in community counseling at Ohio University. During the latter part of my second year in the master's program, I applied for and was accepted into the doctoral program in counselor education.

I chose this topic of study for at least three reasons. One, I believe that work can be a valuable asset in the recovery process from a mental illness such as schizophrenia or schizoaffective disorder. It has been very helpful for me, and the literature suggests that employment is a goal in most individuals' recovery from these illnesses (Kruger, 2000). Definitions of recovery from either disorder vary in the qualitative literature with an emphasis on criteria personally significant to individuals with the disorder (Andresen et al., 2003). *The Vermont Longitudinal Study of 1987* (Harding, Brooks, Ashinkaga, Strauss, and Breier, 1987) suggested a definition of recovery that was adopted in this study as the ideal. This definition is listed in the definition of terms section of this chapter.

The second reason is that people with these illnesses have varied experiences with recovery and employment. It was my hope to give these individuals a voice as to what was helpful in returning to employment because this is lacking in the literature. In addition, mental health practitioners may find a description of what is helpful in working

with people with schizophrenia and schizoaffective disorder in facilitating employment recovery. Finally, people with these illnesses may find the processes of others helpful for their own recovery and employment.

Mental illness has been a part of my life for 19 years. I have weathered many psychiatric storms during that time. It began at a point in my life when most people are establishing themselves in their career – the age of 30 (Super, 1990). My career was put on hold for at least nine years because of my illness. I began the process of recovery in 1994, and it continues to this day. I found I could return to part-time work in 2000 as an undergraduate instructor in a career and life-planning class. I was successful in this capacity; it gave me confidence to apply for a position as a family services coordinator at a local juvenile rehabilitation center. I worked in this position for two and one half years, when I chose to add breadth to my counseling experience by working as an outpatient supervising therapist in a local community mental health center. This is my current employment position.

My own recovery is just that – my own recovery. It is not an ideal recovery that I expect others to emulate; each individual is unique. However, I believed some commonality exists in the processes people in my study have found helpful in recovery to the point of gaining and maintaining employment. It was my hope to elucidate these processes.

Statement of the Problem

I sought to answer the following question: What processes have persons with schizophrenia and schizoaffective disorder found beneficial in their return to work after

diagnosis? I sought to identify the respective individual approaches to finding and securing employment in the face of unemployment rates estimated to be as high as 97% in persons with schizophrenia (Geertsen et al., 2002). A full and descriptive detail of such a process was lacking in the literature.

Significance

The purpose of this study was to fill an existing gap in the literature by providing individually analyzed data from people who had returned to employment after diagnosis of either schizophrenia or schizoaffective disorder. The results advance the existing knowledge base regarding the recovery of persons with schizophrenia or schizoaffective disorder to the point of gaining and maintaining employment.

The results may be helpful for rehabilitation researchers studying individuals with schizophrenia in a furtherance of theory for recovery and employment. Further, the analyzed information gleaned from the study may be useful for psychiatrists, psychologists, mental health counselors, social workers, and nurses working with people with schizophrenia in the furtherance of recovery and employment as potential treatment goals. These mental health professionals might gain further insight into the individual perspectives of recovery and employment for their clients.

Delimitations

This study did not attempt to be representative of the total population of those diagnosed with schizophrenia or schizoaffective disorder in the United States, because it relies only on a sample of eight Midwestern residents with either disorder. This is a delimitation of the study. The lack of generalizability of the analyzed data to individuals

with schizophrenia or schizoaffective disorder in other geographical regions and situations other than those of the interviewees is a delimitation.

This was a qualitative study in the phenomenological tradition using in-depth interviewing (Patton, 1990). No attempt was made to quantitatively analyze the data obtained. This is also a delimitation. The possibility of the observer effect (e.g., the researcher asking specific questions regarding employment affecting the interviewee's answer) was also a delimitation.

Limitations

My own illness of schizoaffective disorder was a limitation in the respect that as unbiased as I attempted to be, the fact that I have the same illness I was studying led to at least some subconscious biases toward the topic of study. A potential bias was the possible belief that if the process that I used in recovery to the point of reemployment was used by others with similar illnesses, they, too, would secure and maintain employment. To guard against this and other potential biases, such as the strong work ethic, I engaged in the phenomenological procedure known as *epoche*. This procedure assisted in the awareness of my biases and how they limited my objectivity toward individuals with schizophrenia or schizoaffective disorder.

Definition of Terms

Epoche is a Greek word meaning “to stay away from or abstain” (Moustakas, 1994).

Iatrogenic illness is a functional disorder brought on by the physician's diagnosis or suggestions (Chaplin, 1985).

Recovery: The Vermont Longitudinal Study of 1987 (Harding et al., 1987)

suggested a definition of recovery from schizophrenia or schizoaffective disorder that includes the following criteria: (a) the ability to meet one's basic needs, (b) no hospitalizations in past year, (c) employment in the last year, (d) leading a moderate to full life, and (e) slight or no symptoms. This definition of recovery is one that was adopted in this study as the ideal. However, the qualitative literature suggested that criteria for the definition of recovery can vary with the individual. In adherence to the qualitative research design of phenomenology, I remained open to these unique definitions as each was discovered by engaging in epoche during the study.

Schizophrenia: Schizophrenia is characterized by the presence of what is referred to as positive symptoms such as delusions, hallucinations, and derailment of speech and negative symptoms such as a flat affect or inability to speak. In addition, there is some degree of lessening of social and occupational functioning or self-care since the onset of the disorder (APA, 2000). The duration of these symptoms must be present for at least six months. Differential diagnoses include schizoaffective disorder and mood disorder with psychotic features and medications, drugs of abuse, or a medical condition causing these symptoms (APA).

Schizoaffective Disorder: Schizoaffective disorder is characterized by an uninterrupted period of illness that includes a major depressive episode or a manic or mixed episode that meets the criteria of schizophrenia. Another characteristic that distinguishes it from schizophrenia is the presence of delusions and hallucinations for a minimum of two weeks in the absence of mood symptoms. The same exclusion exists for

drugs of abuse, medication, or a medical condition for schizoaffective disorder as for schizophrenia (APA, 2000).

Normalcy: A perception of equality with the mainstream nondisabled working population by the participants of this study.

Summary

Given the devastating costs of unemployment and commensurate lack of full participation in society by people with schizophrenia or schizoaffective disorder, the main purpose of this study was to provide further explanation for theory development of what processes those individuals with either disorder who are working found beneficial in returning to work or obtaining their first employment after a respective diagnosis. This was a qualitative study of the phenomenological design. In-depth interviewing was used for data collection.

CHAPTER 2: LITERATURE REVIEW

This chapter reviews the history of the diagnosis of schizophrenia and the literature regarding the etiology and treatment of this disorder. A review of the literature pertaining to recovery from schizophrenia and schizoaffective disorder is included. The chapter ends with a review of the psychosocial rehabilitation literature, vocational rehabilitation literature, and a summary of the chapter.

History of the Diagnosis of Schizophrenia

Pioneers in the Study of Schizophrenia

The history of the diagnosis of schizophrenia begins in the 19th century. The English author John Haslam wrote of symptoms of insanity in his 1809 publication *Observations on Madness and Melancholy* which describe later conceptualizations of schizophrenia. Also in 1806, the French physician Phillipe Pinel wrote about persons who would now be described as having the disorder. In 1859, another French physician, Benedict Morel, used a term which translates into a loss of mind prematurely: *démence précoce* (Barlow and Durand, 1999).

The first formal definition of the mental illness which eventually became known as schizophrenia was by the German psychiatrist Emil Kraepelin (1856–1926), who built on the writings of Morel, Pinel, and Haslam (Barlow and Durand, 1999). He called the condition *dementia praecox*, after two of its distinguishing characteristics: being literally out of one's mind (demented) and the early or precocious (praecox) onset of the disorder (Kruger, 2000). The Kraepelin view which first shaped our understanding of the disease

was of a disease having a progressive and inevitable downward or deteriorating course.

Dementia praecox was synonymous with mental deterioration of varying degrees in Kraepelin analysis (Kraepelin, 1912). Regarding the unfavorable course of dementia praecox:

The outcome of fifty-nine percent of the cases is ultimately pronounced mental deterioration. In these cases, the stupor and excitement disappear and the hallucinations and delusions become less prominent, but the patients give numerous evidence of dementia. They are stupid and indifferent, and have lost their mental activity. They are able to comprehend simple questions, but they lack mental initiative. The memory is defective, the judgment poor, and they are unable to acquire new knowledge (Kraepelin, 1912, p. 253).

A 1992 comment by Harding, Zubin, and Strauss on Kraepelin's work stated that prognosis confirmed diagnosis. If an individual who displayed the symptoms of dementia praecox improved, Kraepelin considered that individual to have been misdiagnosed.

Eugene Bleuler (1857–1939) came next in the social construction of the illness (Bleuler, 1911). He coined the term schizophrenia, literally “the divided mind,” to refer to the disjunction between affect, cognition, and the behavior that is diagnostic of schizophrenia (Kruger, 2000). While allowing for the possibility of social and working recovery, Bleuler's view of prognosis remained bleak. He suggested that the disease could shift, remain stationary, or regress to a previous level but probably could not dissipate to a level of complete restitution (Bleuler, 1924). Bleuler described a group of schizophrenias. Since his description, subgroups such as simple, paranoid, hebephrenic, and catatonic schizophrenias have been delineated, although such distinctions have affected clinical practice to only a limited degree because of the similarities in subgroup symptoms (Kingdon and Turkington, 2005).

More Current Theory

This official concept of schizophrenia continued in recent history to exclude people who recover or improve. *The Clinical Manual of Supportive Psychotherapy* (Novalis, Rojcewicz, and Peele, 1993) took a pessimistic view of the illness and warned the clinician of the chronic nature of schizophrenia while allowing for partial remissions. Kruger (2000) suggested that this type of “iatrogenic hopelessness” (p. 26) could be a factor in why 10% of people with schizophrenia commit suicide (APA, 2000).

One reason suggested for the negative view of recovery from the illness may lie in “clinician illusion,” which may develop when clinicians who treat those who are most severely ill view these clients as typical, although such individuals are actually a small proportion of the actual possible spectrum (Harding and Zahniser, 1994, p. 722). Some researchers estimate that between 17% and 40% of patients with schizophrenia go untreated (Ram, Bromet, Eaton, Pato, and Schwartz, 1992). From this data, Kruger concluded that numerous individuals with schizophrenia are able to function in the community in both family and work roles with minimal assistance from physicians and psychiatrists (Kruger, 2000).

Summary

Beginning with Haslam in 1809 and progressing to the present, several clinicians have contributed to the history of the diagnosis of schizophrenia. Although Kraepelin (1912) and Blueeler (1924) appeared to have a negative prognosis for those afflicted, they were pioneers in the field and had no previous research to guide them in their prognostic endeavors.

Etiology of Schizophrenia

Genetic Influences

The genetic vulnerability to develop the disorder is a well-established finding in the research of schizophrenia (Gottesman, 1991). Genetic studies involving twins, adoption, and family history have all found that the risk for developing the disorder in an individual increases with the degree of closeness of relatives having the disorder (Walker, Kestler, Bollini, and Hochman, 2004); for example, monozygotic twins share 100% of the same genes. If one twin has the disorder, the other has a 50% chance of also developing the disorder, according to most medical research. One dizygotic twin has a 10% to 15% chance of being diagnosed with the disorder if the other is diagnosed (Walker, et al.) As the degree of sharing the same genetic material of a person with schizophrenia decreases, so too does the lifetime probability of developing the disorder for the relative (Walker, et al.).

However, recent analyses of previous research have questioned the 50% concordance rate for schizophrenia among monozygotic twins (Leo, 2003). These analyses examined the most prevalently cited studies of both monozygotic and dizygotic twins regarding schizophrenia (Hoffer and Pollin, 1970; Koskenvuo, Langinvainio, Kaprio, Lonnqvist, and Tienari, 1984; Tienari, 1963, 1968, 1971, 1975). The conclusions drawn from these analyses suggest that monozygotic twins are treated more alike than dizygotic twins are treated. Leo suggested that, in fact, the concordance rate among monozygotic twins is lower than 20% (2003).

More recently, gene analyses, genome scans, and linkage studies have found multiple genes that may be involved in the genetic vulnerability. The genes are the serotonin type 2a receptor gene and the dopamine D3 receptor gene, as well as four chromosome regions (Badner and Gershon, 2002; Mowry and Nancarrow, 2001). The current working hypothesis for schizophrenia is that multiple genes of small to moderate effect confer compounding risk through interactions with each other and with nongenetic risk factors. The number of susceptibility genes, the degree of interaction, and the risk conferred by each gene are all unknown at this time (Mowry and Nancarrow, 2001). Meta-analysis of genome scans has found strong evidence for schizophrenia susceptibility in the 8p and 22q loci (Badner and Gershon, 2002). This analysis also found evidence for bipolar disorder and schizophrenia both on 13q and 22q chromosomes.

Environmental factors have been researched as triggers to genetic vulnerability (Walker et al., 2004). These triggers have been hypothesized to begin in utero or possibly at birth. Cannon (1997), after reviewing the literature on obstetrical complications, concluded that the environmental presence of hypoxia (fetal oxygen deprivation) and other delivery complications was strongly related to later development of schizophrenia. Other researchers (Barr, Mednick, and Munk-Jorgenson, 1990; Brown, Cohen, Haravy-Friedman, and Babulas, 2001) have examined prenatal maternal influenza and rubella as possible environmental contributors. A connection appears probable with the elevated occurrence of schizophrenia in persons born during the winter months (Bradbury and

Miller, 1985; Torrey, Bowels, and Clark, 1997) when viral infections are most prevalent to which a fetus would be exposed (Walker, et al.).

Neuroanatomy Studies

Modern neuroimaging techniques such as computer aided tomography scans, magnetic resonance imagery, and positron emission tomography scans developed with the aid of high-speed computers provide images of the brain structure and functioning of individuals with schizophrenia (Pratt, Gill, Barrett, and Roberts, 1999). From these images, researchers have found the neuroanatomy and neural functioning of the brains of persons with schizophrenia to differ from the brains of those without the disorder (Pratt et al., 1999). Specifically, the ventricles and sulci of the brain are enlarged in people with schizophrenia, which is indicative of less brain tissue than people of the same age without the disorder (Heckers, 1997). The ventricles are large fluid-filled enclosures, and the sulci are the spaces or folds in the brain's cortex (Pratt et al., 1999). Other studies have indicated that the frontal lobes of the brains of people with schizophrenia are underactive (Buschbaum and Haier, 1987). Results of studies of cerebral blood flow studies show similar underactivity in the frontal lobes as well as an overactivity in the temporal and parietal lobes (Buschbaum and Haier, 1987).

Environmental stressors such as drug use, trauma, or ongoing social problems are considered to be possible factors in the development of psychosis in a person who is genetically weighted as being vulnerable to the development of schizophrenia (Kingdon and Turkington, 2005). These possible contributors are hypothesized to combine to

produce symptoms characteristic of the disorders in people. This hypothesis is called the vulnerability-stress model and was developed by Anthony and Liberman (1986).

For most people who develop schizophrenia, the initial phase is the most frightening, because the individual is usually very unstable. This makes accurate diagnosis problematic. In many instances, people who initially receive a mood disorder diagnosis later receive a schizophrenia diagnosis, whereas those who receive a schizoaffective disorder diagnosis tend to have their diagnosis changed at a later evaluation because of symptom progression of either disorder (Chen, Swan, and Johnson, 1998; Weisman, Neinhuis, Slooff, and Geil, 1998).

Treatment

Historically, various treatments have been attempted over the decades of the 20th century either to cure schizophrenia or to control its symptoms. During the 1930s, three treatments were developed, all biologically based. First was insulin coma therapy, in which the person with schizophrenia was given massive doses of insulin. The person would slip into a coma, which was thought to be beneficial to the brain. This therapy was abandoned because of the high risk of death (Barlow and Durand, 1999).

Psychosurgery, in which a prefrontal lobotomy is performed on the person, came next. This procedure involves a severing of nerve pathways in the frontal lobes of the brain after gaining access to them by boring two holes in the skull. This procedure was replaced by transorbital lobotomy, in which an ice-pick-like instrument was forced into the rear of the eye sockets and its point used to pierce the frontal lobes of the brain (da Costa, 1997).

Psychosurgery was replaced by electroconvulsive therapy (ECT), which has limited use today, mostly for treatment of resistive severe depression and depression with psychotic features. ECT is administered to a client who is anesthetized and has received a muscle relaxant to prevent sprains or fractures from therapy-induced convulsions. A grand mal seizure lasting from 25 to 120 seconds is the "...result of electrodes being placed on the scalp and an electric current being passed between them" (Leinbaugh, 2001, p. 41). Fewer than 20% of those receiving ECT have a diagnosis of schizophrenia. However, ECT is indicated for clients with schizoaffective disorder who are a significant suicide risk, who are unresponsive to medication, and who suffer from manic or catatonic agitation (Leinbaugh, 2001).

Medications and Psychotherapy

Many authors agree that combinations of neuroleptics and psychotherapy are the most effective means for treating schizophrenia or schizoaffective disorder (Gould, Mueser, and Bolton, 2001; Kingdon and Turkington, 2005; Walker et al., 2004). However, there is no consensus on what type of psychotherapy works best. Beginning in the 1950s, new drugs called neuroleptics were developed; the first was chlorpromazine (Thorazine). These drugs allowed numerous people with schizophrenia an opportunity to experience living as outpatients instead of in psychiatric hospitals.

However, chlorpromazine has several common side effects which have been demonstrated in many individuals since its inception (Freedman, 2005). These include Parkinsonian-type symptoms (such as tremors), as well as a risk for developing tardive dyskinesia, a movement disorder of the limbs, tongue, or face.

Today's neuroleptics are referred to as typical or atypical. Typical refers to first-generation drugs that were all developed since the 1950s until the advent of the atypical drugs in the 1980s. Numerous typical and atypical neuroleptics exist. They all block dopamine receptors in the brain, thereby reducing dopamine levels there (Walker et al. 2004). This leads to a reduction in symptoms in some people; however, there are potential side effects with the typical neuroleptics. The atypical drugs are less prone to causing involuntary movement side effects, although they have come to be associated with weight gain and commensurate medical problems associated with obesity (Freedman, 2005).

More than 100 controlled studies have shown that 50% to 85% of persons with schizophrenia improve significantly with antipsychotic medication (Lehman, Steinwachs, and PORT Co-Investigators, 1998). The reduction of positive symptoms is most prevalent in these studies. In 2006, a study of neurocognitive efficacy of the atypical medications olanzapine and risperidone and the typical drug haloperidol was conducted (Keefe, Young, Rock, Purdon, Gold, Breier, and HGGN Study Group, 2006). Four-hundred and fourteen individuals with schizophrenia and schizoaffective disorder were treated with olanzapine ($n = 159$), risperidone ($n = 158$), or haloperidol ($n = 97$) (Keefe et al., 2006). At 52 weeks, the olanzapine treatment group improved in processing speed, motor function, learning and memory, attention and vigilance, and verbal working memory more than the haloperidol treatment group, which improved in only memory and learning. The risperidone treatment group improved in all of the previously mentioned domains, including visuospatial memory. However, the mean change analyses suggested

no significant differences in neurocognitive efficacy on the basis of medications. This is an interesting finding in that the costs of atypical medications are significantly higher than the costs of such typical medications as haloperidol.

Salkever, Slade, and Karkus (2006) analyzed data of the earnings of schizophrenia patients to determine whether the higher cost of atypical medications is offset by an increase in earnings for that population. They examined 2,327 adults with schizophrenia from the Schizophrenia Care and Assessment Program, which is a three-year longitudinal study of adults from six areas of the United States. The researchers identified 336 people who were in the maintenance phase of their antipsychotic treatment. The maintenance phase occurs when medication dosages are stable and symptoms of the illness are manageable. Salkever and colleagues concluded that earnings would be \$107 to \$122 higher per month with atypical rather than typical medications.

Cognitive-behavioral therapy (CBT) has been studied as a psychotherapeutic treatment type (Gould et al., 2001; Kingdon and Turkington, 2005; Pilling, Bebbington and

Kuipers, 2002) and continues to be the focus of meta-analysis. A 2006 meta-analysis of studies using CBT for psychosis sought to clarify symptomatic improvement that is clinically significant (Gaudiano, 2006). This is in contrast to findings of statistical significance that do not specifically detail clinical aspects. The analysis consisted of 48 reports including CBT, which was broadly defined as interventions containing explicit cognitive and behavioral components that target positive and negative symptoms of psychosis. Gaudiano argued for the use of clinical significance in outcome trials as

opposed to statistical significance. According to Gaudiano (2006), statistical significance determines whether or not an observed difference is likely caused by chance, whereas clinical significance determines a measurable change in treatment gains. Clinical significance is the measure in which Gaudiano was most interested.

Gaudiano (2006) used a reliable change index (RCI) criterion, which takes into account the reliability of the various studies' assessment instruments to determine error attributable to measurement of treatment gains in those studies. The RCI score is indicative of a real difference compared with a statistical difference and ensures comparability between studies. The RCI was calculated for each psychotic symptom measure in the studies. A reduction in symptoms of two standard deviations was used to determine clinical significance. CBT was defined as interventions which contained cognitive restructuring and skills training targeted toward positive or negative symptoms of psychotic disorders.

Results of the Gaudiano (2006) study demonstrated that 33% of studies compared showed reliable improvement in at least one symptom measured. Standardized outcome measures which assess psychotic symptoms were included in the analyses. The study used Sheldrick, Kendall, and Heimberg's (2001) box score method for calculating reliable change in the group data studied. This box score method has been used in studies of treatment for conduct disorder and bulimia (e.g., Lundgren, Danoff-Burg, and Anderson, 2004). Measures showing reliable change estimated the clinically significant change to be 48%. This finding is in contrast to 16% of all measures showing average

clinically significant improvement. In addition, treatment setting (either inpatient or outpatient) showed no significant reliable clinical change (Gaudiano).

A meta-analysis of 14 studies of CBT sought to determine whether CBT improves the management of positive symptoms of schizophrenia (Zimmerman, Favrod, Trieut, and Pomini, 2005). Treatments used for comparison in that study were non-specific treatment, waiting list, and treatment as usual. The global weighted mean effect size (a calculation of the mean effect sizes over the 14 studies) of CBT was 0.37, suggesting a modest improvement. However, when only the blind studies were considered, the effect size was 0.29. The results further show that CBT is more effective for people in an acute psychotic episode than it is for chronic stabilized people with schizophrenia and schizoaffective disorder. Zimmerman et al. (2005) cited the heterogeneous non-specific treatments included in the study as limitations. In addition, the methodological differences of each study were not completely investigated. This brings into question the validity of the 14 studies and their respective conclusions.

A comparison study of brief group CBT and a group Psychoeducational (PE) program in Germany was conducted with 48 inpatients with schizophrenia (Bechdorf, Kohn, Knost, Pukrop, and Klosterkötter, 2005). These patients were randomized to receive either CBT or PE treatment and were assessed at six-month and 24-month follow-ups. Primary outcome measures at six and 24 months included rehospitalization, schizophrenia symptoms, and compliance with medications. The overall length of rehospitalization stays averaged 92 days in the CBT group and 163 days in the psychoeducational group (Bechdorf et al.). This was not statistically significant, nor was

it associated with medication compliance at posttreatment or 24-month follow-up. The researchers argued that in comparison to PE, brief group CBT “significantly improves the short-term prognosis of many people with schizophrenia and the long-term prognosis on a descriptive level” (Bechdolf et al., p. 179).

Recovery

All of the models of recovery have similar themes: (a) a realization that the illness is only a part of the person’s life, (b) a reevaluation and modification of goals, (c) control of symptoms, and (d) an effort to maintain a personally meaningful life. Recovery from the illness of schizophrenia has various meanings to each individual. The word “recovery” has been used to describe the progressive struggle for higher functioning of those afflicted. Kruger (2000) cited *The Vermont Longitudinal Study of 1987* by Harding et al. as suggestive of the criteria for recovery:

1. Not in the hospital in the past year.
2. Able to meet basic needs.
3. Led a moderate to full life.
4. Employed in the last year.
5. Slight or no impairment in functioning.
6. Displayed slight or no symptoms (p. 723).

In *The Vermont Longitudinal Study* (Harding et al., 1987), a cohort of 269 people was selected on the basis of the chronicity of their schizophrenia disease. These people were recruited from the local mental hospital and were profoundly ill, severely disabled, and met guidelines for the diagnosis of schizophrenia according to *The Diagnostic and*

Statistical Manual, 1st Edition, (APA, 1952). The manual's first edition criteria for schizophrenia were used because of the date of the start of the study in 1955. Kruger (2000) stated that during these people's follow-up (which averaged 32 years), they were deinstitutionalized and were assisted in accessing rehabilitation programs. The data obtained from assessment were surprising: 26% of the participants were employed; of those, more than three-quarters were earning adequate incomes, nearly 50% were in or had been in an intimate, long-term relationship, and 90% were living independently or semi-independently. Thirty-two years after discharge from the hospital, 68% of the participants were rated by the authors as having mild symptoms (i.e., insomnia) and functioning at a level that untrained people would consider normal. This might suggest that the long-term prognosis for schizophrenia is less severe than previously thought.

Longitudinal studies from the 1970s and 1980s (Blueier, 1978; Ciompi, 1980; Huber, Gross, and Schuttler, 1980; Tsuang, Woolson, and Fleming, 1979) assessed 1,300 people two to three decades after first hospitalization. Two thirds were found to be considerably improved or recovered. These results suggest that schizophrenia has a long-term prognosis that is good, contrary to Kraepelin's view, which has been embraced by the medical community for a long time.

Thompson, McGorry, and Harrigan (2003) assessed recovery style in people with first-episode psychosis and found that it may be a useful predictor of outcome. They found that recovery from psychosis is correlated with either an integration of the illness experiences into the wider life situation or a seal-over of the illness experiences to minimize a loss of mental integrity. Seal-over could be considered a form of denial of the

illness and is related to self-protection by the individual from stigma associated with psychosis. Those with integrative recovery styles were found to have better outcome and functioning at 12 months after stabilization of their illness.

Andresen and colleagues (2003) sought to empirically validate a stage model of recovery. The definition of recovery that they found was the one used by consumers for psychological recovery from the consequences of their illness. Four key processes of recovery were identified as (a) finding hope, (b) re-identity, (c) finding meaning in life, and (d) taking responsibility for recovery.

Andresen et al. (2003) constructed a five-stage model of recovery from analyzing a pattern from the studies they researched (Baxter and Diehl, 1998; Davidson and Strauss, 1992; Pettie and Triolo, 1999; Spaniol, Wewiorski, Gagne, and Anthony, 2002; and Young and Ensing, 1999). These studies were all qualitative and led to the following conceptualization of a five-stage model:

1. Moratorium: This stage is characterized by denial, confusion, hopelessness, a confused identity, and protective self-withdrawal.
2. Awareness: The person has a first glimmer of hope of a better life, and that recovery is possible. This can be an internal event, or can be sparked by a clinician, significant other, or a role model. It involves an awareness of a possible self other than that of a sick person; a self that is capable of recovery.
3. Preparation: The person resolves to start working on recovering. This stage involves taking stock of the intact self, and of one's values, strengths, and

weaknesses. It involves learning about mental illness and services available, recovery skills, becoming involved in groups, and connecting with peers.

4. Rebuilding: In this stage, the hard work of recovery takes place and the person works to forge a positive identity. This involves setting and working towards personally valued goals, and may involve reassessing old goals and values. This stage involves taking responsibility for managing the illness and taking control of one's life. It involves taking risks, suffering setbacks, and coming back to try again.
5. Growth: This final stage of recovery could be considered the outcome of the process. The person may not be free of symptoms completely, but knows how to manage the illness and to stay well. The person is resilient in the face of setbacks, and has faith in his or her own ability to pull through and maintain a positive outlook. The person lives a full and meaningful life and looks forward to the future. He or she has a positive sense of self, feeling that the experience has made him or her a better person than he or she might otherwise have been (Andresen et al., 2003, p. 591).

These stages surfaced as being present in the analysis of the interviews of people with schizophrenia or schizoaffective disorder. They were also used as a guideline for developing questions for the interviewees.

The Stages of Recovery Instrument (Andresen et al., 2003) has been developed to test the validity of the five-stage model and to investigate the possible pattern of processes across the individual's stage of recovery. The stage model of recovery

mentions relationships with peers or role models as being a factor in both the awareness and preparation stages of recovery. Such relationships are hypothesized to aid in the recovery process (Andresen et al.).

The stage model of recovery of Andresen et al. (2003) is similar to the findings of Spaniol et al. (2002) in a qualitative study of 12 individuals with schizophrenia or schizoaffective disorder over a four-year period. These people had previously received interventions to improve vocational functioning and were sufficiently motivated to recover, according to the authors. Analyzing the interviews of these respondents led the researchers to conclude that recovery progresses through three broad phases: overwhelmed by, struggling with, and living with the disorder. Further, as the participants moved through the phases, they were faced with three tasks: (a) seeking an explanation for their experience, (b) trying to control the illness, and (c) attempting to establish themselves in productive roles. Establishment in productive roles in life is in concert with Anthony's (2003) assertion that recovery from mental illness involves finding new meaning and purpose in life for those so afflicted.

Jacobsen and Greenley (2001) described recovery as recovering part of the self that is lost to the illness by realizing that the illness does not define the whole person. They developed a model of recovery which incorporates internal and external conditions. Internal conditions include attitudes, experiences, and the process of change, whereas external conditions refer to policies and practices which aid recovery (Torgalsbeen, 2005).

Hope

Recovery has another theme that the literature suggests is an important part of the process: hope. References to hope abound in the literature on recovery. Such references were found by Andresen et al. (2003) in 19 of 28 consumer narratives. They were also found in nine of 10 consumer articles and in all of the eight qualitative articles published in refereed journals reviewed by Andresen et al.

Snyder, Michael, and Cheavens (1999) have defined hope as consisting of three distinct elements: (a) a goal, (b) envisaged pathways to the goal, and (c) belief in one's ability to pursue the goal. Miller (1992) described hope as anticipation of a continued good state, an improved state, or a release from perceived entrapment. Andresen et al. (2003) further describe hope as coming from within the person or as being triggered by a significant other, peer, or role model.

Hope is not only the trigger for recovery, but also maintains the recovery process: I have met people who have healed from this disorder and what has distinguished them from others was the belief that they could heal. They were also determined to do the necessary work. (p. 588)

Andresen et al. (2003) found the loss of a sense of identity with schizophrenia and the process of self-redefinition to be central to recovery. This is expressed in the following quotation from a client with schizophrenia: "My illness eradicated my sense of self, and now I am engaged in the lifelong process of obtaining, maintaining, and slowly modifying my sense of who I am" (p. 590).

Finding meaning in life is an area touched on by Murphy (1998): An integral part of my recovery has been my search and discovery of meaning for my life. This is a philosophical and psychological issue that goes beyond mere chemical imbalances in the brain. In this search I have developed a new world view. (p. 187)

Taking responsibility for one's recovery is also vital to the recovery process (Andresen et al., 2003). One consumer spoke of the need to take responsibility for his own recovery and not just wait for the pills to do it all. This is an expression of hope for self as listed by Andresen et al. (2003). Developing goals could be an aspect of taking responsibility. The power of meeting small goals to engender hope is illustrated in an account found in Davidson (1993) of a female patient being proud of purchasing her first, very own, spool of thread. After this accomplishment, this person had an improvement in mood from despair to eager exploration as she became active in investigating social and rehabilitation programs.

Psychosocial Rehabilitation

Employment Literature

The current literature on the prognosis of schizophrenia is more optimistic than that developed even 10 years ago. There is increasing evidence that people with schizophrenia can, and do, hold positions of employment sufficient for self-sustenance. A recent study of 109 people with a self-reported diagnosis of a schizophrenia spectrum disorder found that 75% had uninterrupted employment during the two years before entering the study and that the rest sustained employment for at least 12 months during the same period (Ruscinova, Wewiorski, Lyass, Rogers, and Massaro, 2002). Vocational recovery was defined as "the outcome of preserving, regaining, or acquiring competitive employment after being affected by a serious mental illness" (Ruscinova et al., p. 303). Stability of workforce participation was operationalized in the study as six months of employment per year, with a threshold of 10 hours of work per week that is consistent

with the Social Security Administration's requirements for a trial work period (Social Security Administration, 1995). This study further found that people with schizophrenia have the capacity to sustain employment at all levels, from unskilled to professional positions.

Initiatives to employ people with serious mental illness as providers of mental health services have been undertaken (Mowbray et al., 1997). Although a cursory view of these initiatives by laypeople could lead to the expectation that the majority of people with schizophrenia can be employed in either mental health services or low-level jobs, Russinova et al. (2002) found fully 59% of those studied were working in nonhelping settings. Approximately 25% held professional positions.

Russinova et al. (2002) concluded that although schizophrenia presents major challenges to those affected, it does not obviate the possibility of successful employment. They found several factors to be associated with vocational outcomes: Social Security benefits, education, prior work history, and vocational participation in mental health advocacy and organizations. These factors are all potentially malleable by designing interventions such as supported education, increased incentives from Social Security for work, and employment opportunities for people who are advocates for their peers within mental health programs. It would also appear that legal action in support of individuals with schizophrenia or schizoaffective disorder could be an effective intervention for those people in gaining and maintaining employment.

Americans with Disabilities Act

People with disabilities of all types were assisted in obtaining and maintaining employment by the legal intervention known as the Americans with Disabilities Act (Olsheski and Schelat, 2003). On July 26, 1990, President George H. W. Bush signed into law, with bipartisan congressional support, the Americans with Disabilities Act (Olsheski and Schelat, 2003). It was described as “the most significant piece of civil rights legislation since the passage of the 1964 Civil Rights Act” (O’Keffe, 1994, p. 1). The ADA evolved from the Rehabilitation Act of 1973, which defined the condition of being handicapped and prohibited discrimination of persons so defined (O’Keffe, 1994).

The ADA consists of five titles which prohibit discrimination based on disability in employment, public accommodations, public services, transportation, and telecommunications. Although all titles are important to people with disabilities, the focus in this study is on employment, which is covered in Title I of the ADA.

Title I prohibits employers from discriminating against a person with a disability on the basis of his or her disability if he or she is qualified for the position. Discrimination is prohibited in areas of hiring, promotion, job training, and the discharge process of employment. The title is in force for employers of 15 or more employees. The ADA defines a qualified person with a disability as an individual who can perform the essential functions of the job held or desired with or without reasonable accommodations (Adams, 1991).

Modifications that fall under the boundaries of reasonable accommodations include the following: physical modifications to the workplace to make it more accessible

to persons with disabilities; restructuring a job to the extent that the essential functions can be performed by an individual with a disability; modifying the work schedules of persons with disabilities; reassignment to a vacant position; provision of equipment and qualified readers or interpreters; and modification of the job application process and company policies (Rubin and Roessler, 1995).

Reasonable accommodations by employers are limited to modifications which do not create an undue hardship on them. The ADA defines an undue hardship as any type of action creating “significant difficulty or expense given the size of the employer, the resources available, and the nature of the operation” (U.S. Equal Employment Opportunity Commission, 1992, pp. 111–112).

The ADA could be considered to have been effective during the first few years after its implementation into law. Figures from the Equal Employment Opportunity Commission (EEOC) indicate that the number of complaints filed under Title I approximated 28,000 from July 26, 1992, to May 31, 1994; of those, 66% were found to have sufficient cause (Olsheski and Schelat, 2003). It is unclear how many of those complaints involved people with psychiatric disabilities. However, the EEOC reports discrimination of such persons to be one of the chief workplace complaints (Pardeck, 1999).

The employment of people with disabilities was addressed with the passage of the ADA (Olsheski and Schelat, 2003). Although the current study did not attempt to find statistical data regarding the effectiveness of the ADA, the process of in-depth interviewing allowed open discussion of if, and to what extent, this act affected the

interviewees by asking the question of how any supports were or are used in their employment.

Individual Aspects of Employment

Russinova et al. (2002) suggested institutional changes could minimize unemployment for individuals who suffer from schizophrenia. However, they did not examine the ADA as a potential factor in the employment of such individuals. Further, they did not identify personal factors unique to the individual in gaining and maintaining employment when faced with the illness.

Cunningham, Wolbert, and Brockmeier (2000) used a comparative and qualitative approach to seek further understanding of factors involved in the gaining and maintaining of employment with this population. The study used open-ended interviews with 17 people involved in an Assertive Community Treatment program in Kalamazoo, Michigan. Sixty percent of the people involved in the program had a diagnosis of a thought disorder, primarily schizophrenia. Employing the Brief Psychiatric Rating Scale as a measure, Cunningham, Wolbert, and Brockmeier (2000) used a comparative and qualitative approach to seek further understanding of factors involved in the gaining and maintaining of employment with this population.

They found that the members of Group 1 who had been successful in gaining and maintaining employment for at least six months tended to view their illness as just one part of who they were as individuals (Cunningham et al., 2000). People in Group 3 who had been unsuccessful in gaining employment either were in denial that they had an illness or were consumed by the illness (Cunningham et al., 2000). The people in Group 2

(who were successful in obtaining but not in maintaining employment) had the ability to see themselves as “having an illness” rather than “being an illness” as those in Group 3 appeared to see themselves (Cunningham et al.).

The three groups also differed in their coping skills for bad days. Group 1 members described relaxation as very important in controlling their symptoms and dealing with bad days. Group 1 members tended to see beyond their illness, recognized tomorrow as a new day, and reminded themselves that things would get better. People in Group 2 tended to focus on the moment and did not refer to the transitory nature of the problem. People in Group 3 used strategies which tended to cover up the problem with another substance other than prescribed medication or else they tried to push it away (Cunningham et al., 2000).

Cunningham et al. (2000) concluded that how people manage their illness may be less significant than how an individual manages his or her life while having an illness. Further, emphasizing strategy development that helps people gain perspectives of the kind found in the first group may be more effective than focusing on controlling symptom levels in helping the individuals who are severely mentally ill gain and maintain employment.

The perspectives of those people in all groups were determined from a qualitative study. However, this study failed to identify the processes involved in gaining each group perspective. If these processes were determined, a greater understanding of possible interventions to change such perspectives could be developed.

Self-Efficacy

Cunningham et al. (2000) emphasized individual perspectives on the illness as a possible predictor of employment outcome. Other authors have looked to factors such as self-efficacy as predictive of employment outcome (Anthony, 1994; Arns and Linney, 1993; Regenold, Sherman, and Fenzel, 1999). Regenold et al. (1999) examined 86 people, 28% of whom were diagnosed with schizophrenia and were involved in supported employment. The primary hypothesis in that study was that there is a relation between degree of self-efficacy in people studied and their attainment of employment goals.

Regenold et al. (1999) also hypothesized that those people with a previous employment history and with a lesser degree of psychopathology would be more likely to achieve their employment goals. The authors concluded that degree of self-efficacy is positively related to employment goals. That conclusion is consistent with other researchers' expectations (Anthony, 1994; Arns and Linney, 1993). There was a significant negative relationship between symptomatology and whether an employment goal was attained, also consistent with other research (Anthony, 1994). Regenold et al. further suggest that self-efficacy could mediate between symptomatology, previous work history, and the outcome variable.

Although the previously mentioned researchers' expectations were bolstered by the Regenold et al. (1999) study, none sought to determine the processes that people with schizophrenia have found helpful in returning to and maintaining employment. A

qualitative study giving voice to these people could be helpful in determining the processes they followed.

Barriers to Employment

Stigma is a major barrier to employment of people with schizophrenia or schizoaffective disorder (Pratt et al., 1999). One source of stigma is the way the media portray persons with any type of mental illness as emotionally unstable and dangerous (Pratt et al.). A review of newspaper articles concerning mental illness by Roberts and Rotteveel (1995) found more than 60% of the articles portrayed persons with mental illness as criminals. Another form of stigma is that some professionals believe that people who are psychiatrically disabled are unable to work or able to perform only menial jobs (Pratt et al.).

Rutman (1994) described nine of the barriers to employment that mentally ill people face. He described the cognitive, affective, and interpersonal deficits which are often present in mentally ill individuals as a barrier. He touched on the episodic and unpredictable nature of most mental illnesses as also being a barrier. Various treatment interventions can produce iatrogenic affects on persons with severe psychiatric disabilities, according to Rutman (1994). Inappropriate values, attitudes, and aspirations regarding work resulting from a mental illness were also considered, as were the conflicting definitions and taxonomies regarding psychiatric illness and rehabilitation. Tensions and discontinuities between the major service systems which work with persons with psychiatric disabilities were considered a further barrier, as well as work disincentives created by Social Security Administration provisions governing financial

support and medical insurance (Rutman, 1994). In addition, significant difficulties existed in assessing clients' work readiness and predicting vocational outcomes. Finally, Rutman considered stigma toward persons with a mental illness in our society as affecting a person's opportunities for employment. He concluded by stating that stigma toward persons with mental illness is present at many levels in our society and adversely affects opportunities for the employment of those persons.

Although Rutman (1994) defined the barriers to employment for people with schizophrenia, Peckman and Muller (1999) considered ways to improve employability for individuals with schizophrenia. Semi-structured interviews were used with seven people diagnosed with schizophrenia. Peckman and Muller found four groups of barriers that were associated with having schizophrenia: (a) interpersonal, (b) episodic and unpredictable symptoms, (c) treatment interventions, and (d) inappropriate values (p. 400).

These barriers were in alignment with Rutman's (1994) barriers to employment for individuals with schizophrenia. Regarding coping strategies, the participants cited openness with their employer, taking everything step-by-step, and using positive self-talk as making life at work easier. Practical solutions to the barriers faced in the workplace fell into four categories: "(a) support (e.g., hotline or workshops); (b) education (for employers and community); (c) personal training (money management, problem solving, support and medical insurance)" (Rutman, 1994, p. 21). In addition, significant difficulties existed in assessing clients' work readiness and predicting vocational outcomes. As

previously stated, Rutman considered stigma toward persons with a mental illness in our society as affecting a person's opportunities for employment.

Vocational Rehabilitation

A qualitative study by Lord, Schnarr, and Hutchinson (1987) revealed that employment was the one need mental health consumers most often documented as being important. But is this need being met by vocational rehabilitation services? Andrews, Barker, Pittman, Mars, Struening, and LaRocca (1992) found that, compared with other forms of disability, people with psychiatric disorders traditionally have the lowest success rates for vocational rehabilitation. The following sections review possible reasons for these low success rates.

Workplace Climate/Consumer Value Fit

Kirsch (2000) found that a congruence of workplace culture and climate and values of persons were important factors associated with continuing employment for consumers. Kirsch studied 36 participants, 75% of whom reported a diagnosis of schizophrenia or schizoaffective disorder. It is not clear if the remaining 25% had a psychiatric diagnosis. The participants were highly similar in demographic characteristics and were placed in one of two groups:

- (1) people who were working in mainstream employment and had maintained their employment for at least six months ($n = 17$) (Kirsch, p. 3, 2000).

or

(2) people who had left their employment in integrated settings within the six-month period before recruitment (either because they were asked leave or chose to leave) ($n = 19$). All participants had experienced significant disruption and turmoil in the social and vocational areas of their lives as a result of their mental illness (p. 3).

Kirsch (2000) studied individual/environment fit for effective employment tenures and found a correlation for such a fit with employment tenure. Bell, Lysaker, and Milstein (1996) described levels of expectation for 150 individuals with a diagnosis of schizophrenia or schizoaffective disorder. These people were assigned to three levels of expectation in a rehabilitation program, each differing in the number of hours per week participants were expected to work. The group that produced the most weeks of work was a self-regulation group in which participants could choose as few or as many hours to work as they deemed appropriate. This finding could be interpreted as supporting the Kirsch findings in that the self-regulation group members were using more of their individualism and fitting into the work environment more because of their own desires than the high expectation or low expectation groups. The approach of supported employment in vocational rehabilitation for people with severe mental illness (including schizophrenia) has included informed choices of the individual, which could be interpreted as a move toward individualism in employment choice and tenure.

Supported Employment

McGurk, Mueser, Harvey, LaPuglia, and Marder (2004) conducted a review of research on people who were severely mentally ill and competitive employment by the

supported employment program. They looked at the relationship between cognitive functioning and symptoms with such employment. They noted various reasons which tend to suggest that cognitive impairment worsens work problems. One reason is that cognitive impairment precedes role impairment in schizophrenia. Another is the relative stasis of cognitive impairment even when people with severe mental illness gain employment (Hafner, Maurer, Loffler, van der Heiden, Hambrecht, and Schultze-Lutter, 2003). However, McGurk et al. found no evidence to suggest that work problems worsen cognitive functioning or that work reduces cognitive impairment. Nine studies of clients not in vocational rehabilitation programs (Bellack, Gold, and Buchanan, 1999; Gold, Queern, Iannone, and Buchanan, 1999; Goldberg, Lucksted, McNary, Gold, Dixon, and Lehman, 2001; McGurk and Meltzer, 2000; Meltzer and McGurk, 1999; Mueser, Salyers, and Mueser, 2001; Palmer et al., 2002; Schuldberg, Quinlan, and Glazer, 1999) found a broad range of cognitive functioning to be related to work status. One study of clients not in vocational services found cognitive functioning to be a predictor of later work (Westermeyer and Harrow, 1987).

Becker, Miesler, Stormer, and Brondino (1999) analyzed outcomes for clients in a psychosocial and vocational rehabilitation program called Program for Assertive Community Treatment. The program outcome studies lasted for nine years and two months (December, 1984, to February, 1994). A total of 184 clients with a diagnosis of schizophrenia or major affective disorder were included. The program was staffed on a 24-hour basis, seven days per week. Becker et al. used information from discharge

summaries, case management notes of weekly home visits, daily records of any contact the client had with staff, and the clients' dates and hours of weekly employment.

The researchers concluded that 64% of the program participants who stayed in the program for one year or more attained some type of employment. The average rate of employment for all participating clients in the program over the time period studied was 33%. The Becker et al. study failed to describe the geographic locations of the program. The location of the program, rural or urban, could have a major effect on the outcome of the study. Cultures differ in rural and urban communities and different regions of the country with regard to employment (Pratt et al., 1999).

Fountain House

In the late 1940s, a support group was formed by ex-patients of the Rockland Psychiatric Center in New York state (Pratt et al., 1999). It began meeting on the steps of the New York Public Library. The National Council of Jewish Women became aware of this group and began to offer support. With the help of Elizabeth Schermerhorn, a building was purchased as a clubhouse for the group. It was named Fountain House and was originally staffed by its members and volunteers. John Beard was hired as executive director in 1955. He helped to promote the clubhouse movement into a worldwide program. Since its inception, Fountain House in New York has been a resource in assisting members in the area of employment.

Fountain House was one of the original psychosocial rehabilitation clubhouses which included work (Pratt et al., 1999). Fountain House uses the modality of clubhouse members working alongside staff to maintain and operate the clubhouse. Members gain

self-confidence and self-esteem and are given an opportunity to contribute (Beard, Propst, and Malamud, 1994). Fountain House has also been instrumental in the development of transitional employment for people with mental illnesses, including schizophrenia and schizoaffective disorder (Pratt et al.).

Transitional employment involves a vocational agency providing people with mental illness as workers for competitive jobs. Staff members of the vocational services agency are available to do the job if the individual worker misses work. The staff member knows the job well by performing it for a substantial period of time before the person with a disability is placed in the position. Program members work the job from three to nine months before they are rotated to another job. All jobs are generally part-time and require minimal skills (Pratt et al., 1999). “The Fountain House . . . members will experience as many transitional employment jobs as are needed to eventually achieve permanent employment in jobs of their own” (Beard et al., 1994, p. 26).

Choose–Get–Keep

Another psychosocial rehabilitation approach is known as choose–get–keep (CGK) and was developed at Boston University by Danley, Anthony, and Howell in 1984 (Danley and Anthony, 1987). The CGK model is not setting specific such as the Fountain House program. It consists of a focus on an individual consumer and practitioner in diagnosis, planning, and intervention to assist the person in choosing, getting, and keeping a rehabilitation goal (Anthony, Cohen, Farkas, and Gagne, 2005).

The settings in which a CGK are implemented depend on the consumer’s preference of where he or she wants to work. A particular setting may be a location

where manual labor is performed or a location where white-collar positions are available (Ruscinova, Ellison, and Foster, 1999). In addition to meeting the preferences of the individual, a setting may also accommodate the person's skill levels. Skill levels have been studied by researchers and outcomes exist from such studies (Roder, Jenull, and Brenner, 1998; Tsang, 2001).

Skills Training

Teaching people with schizophrenia recreational, residential, and vocational skills could be an effective solution for gaining and maintaining employment. Roder et al. (1998) studied these important issues. They evaluated three therapy programs designed for the further development of integrated psychological therapy (IPT) in Europe. These three programs were categorized as recreational, residential, and vocational therapies. IPT is a structured therapy approach which uses improvements in cognitive and social functioning to prepare people with schizophrenia for life outside a hospital setting. IPT seeks to improve cognitive and social functioning by providing social skills training in work, housing, and leisure-time activity. The focus of training is on individual needs, options, and skills. Support is provided for putting a solution to one of the areas into action for the individual. Teaching clients to anticipate problems which may occur in any of these new areas and assisting them in dealing with such problems is also a goal.

Each therapy program in IPT therapy is divided into three units devised to address specific topics. In the first unit, the focus of training is on acquiring action-oriented cognitive skills. The second unit focuses on the practical implementation of skills which

were acquired in the first unit. The third unit involves solving problems, attaining goals, and maintaining long-term therapy gains. The program also consists of four different formats of therapeutic interventions: group therapy at the treatment site, individual therapy sessions, group activities which are not part of regular group therapy and which take place outside the treatment site, and homework assignments between sessions (Roder et al., 1998). The researchers concluded that three to six months after therapy, booster sessions could provide people with schizophrenia guidance and support in dealing with emerging difficulties which develop after an individual is employed.

A 2005 study sought to determine whether a supplementary social skills training program improved outcomes for 35 employed clients with severe mental illness who were receiving supported employment services at a free-standing agency (Mueser et al., 2005). Clients were randomly assigned to three groups: (a) a workplace fundamentals program (i.e., identifying workplace stressors and problem solving), (b) a skills training program consisting of efforts to make work more satisfying and successful, or (c) treatment as usual. The clients in the workplace fundamentals group improved in knowledge of fundamentals of the workplace at the nine-month follow-up compared with the control group. However, the two groups did not differ in measures of hours or days worked, salaries earned, or use of additional vocational services over an 18-month period. This study differed from most previous studies because of the higher educational levels and better employment outcomes of the clients studied. The researchers concluded that these client factors make detecting possible effects of skills-training intervention on work difficult. Further, supplementary skills training did not improve work outcomes.

Individual Placement and Support

In the late 1980s, supported employment was implemented in the United States on the state level through a combination of state mental health authorities with state vocational rehabilitation services (Knisley, Hyde, and Jackson, 2003). This initiative spurred the individual placement and support (IPS) model of vocational services (Becker, Bond, and McCarthy, 2001; Becker and Drake, 1994). This model is similar to one used with people who are not mentally ill and are seeking employment in the competitive job market and learning by doing the job, with the addition of necessary supports and job coaching (Bond, Drake, and Mueser, 1997; Drake et al., 2000).

Lehman, Goldberg, Dixon, McNary, Postarado, and Hackman (2002) compared the IPS program with usual psychosocial rehabilitation services for employment of inner-city residents with schizophrenia. The research was conducted with 219 outpatients, 75% of whom had chronic psychosis. Assessments were made every six months for two years. The researchers concluded that the IPS program was more effective than the psychosocial rehabilitation program in the facilitation of employment goals for those studied (Lehman et al.).

A random-effects meta-analysis of 1,340 participants from seven sites of the Employment Intervention Demonstration Program sought to examine the effects of job development and job support compared with other services on gaining and retaining competitive employment (Leff, Cook, Gold, Toprac, Blyler, Goldberg, McFarlane, Shafer, Allen, Camacho-Gonsalves, and Raab, 2005). The researchers found that job development was very effective for job acquisition. Furthermore, job support was

associated with job retention of a first competitive job, but its causal effect is still in question.

Research in Different Countries

Integration of Work Skills and Social Skills

Tsang (2001) integrated social skills training with a work skills module involving 97 participants with schizophrenia. Participants were randomly assigned to three groups: training with follow-up support, training without follow-up support, and a control group which received assessment only. The program which was used evolved from the job club developed by Jacobs, Kardushian, and Krienbring (1984). A job club is an informal organization of people who assist each other in job searches and mock interviews.

The module developed by Tsang (2001) is a three-tiered directed program beginning with social skills training. The first tier covers interpersonal communication and basic job skills such as grooming and politeness. The second tier involves training and role playing in the general skills needed for securing and keeping a job. Such skills consist of presenting a positive impression in the job interview and developing and maintaining a good working relationship with supervisors, coworkers, and subordinates. The third tier focuses on the benefits of obtaining employment: (a) salary, (b) structure, (c) sense of achievement, (d) personal satisfaction, and (e) the maintenance of employment. Training consisted of ten weekly sessions of one and a half to two hours. Forty-seven percent of the participants in the training plus a follow-up group were employed at the three-month follow-up assessment (Tsang, 2001).

A limitation of this study was the fact that participants involved had a very high level of functioning and were motivated to join a group in which they could work toward competitive employment. It is unclear if such a training program would have the same results with moderate to low functioning people or those who were indifferent to employment. Another limitation is the geographic location and cultural generalizability of this study, which was conducted in Hong Kong.

Waghorn, Chant, and Whiteford (2003) investigated Australia's unemployment of persons with schizophrenia and researched the strength of self-reported course of illness as a predictor for vocational recovery in persons with schizophrenia. Unemployment among people with schizophrenia in Australia was estimated by these authors to be 72%. This figure is similar to the 75%-90% estimate of the unemployment rate among American people with schizophrenia by some researchers (Jablensky, McGarth, and Herman, 1999). The actual unemployment rate in the sample of 380 persons diagnosed with schizophrenia was 83.7% for men and 87.0% for women. This rate represented a rate 10.6 times higher than for all Australians in the same year (Australian Bureau of Statistics, 1998). The sample was also different from educational level estimates in Australia, in that 87.7% of the sample had no post-school qualifications in comparison to 11.2 % of all Australians who had no post-school qualifications (Waghorn et al.). Results suggested that those people with a chronic illness with clear deterioration were 10 times more likely to be unemployed than those reporting a single episode with good recovery.

Waghorn et al. (2003) concluded that people with more severe courses of illness and disrupted secondary education are more likely to need help to obtain and retain

employment. This finding is consistent with Mueser et al. (2001), who found that the education level of people with schizophrenia and their mothers' education level predicted working at one- and two-year follow-ups.

Marwaha and Johnson (2004) used the keywords *schizophrenia, psychosis, mental disorder, work, employment, occupation, vocation, and job* to identify papers which discussed schizophrenia and employment in the United Kingdom. They sought to answer questions regarding the employment rate in people with established schizophrenia, the barriers to employment, factors associated with being employed among people with schizophrenia, and evidence that being employed influences other outcomes in schizophrenia. In answer to the first question of the employment rate in people with established schizophrenia, the authors found numerous methodological flaws in attempting to compare the data expressed in a number of reports. They cited the difficulty of knowing in the various reports if the rates expressed are for "open, sheltered, voluntary, part-time or full-time employment, what time-frame has been used for measurement and how far definitions require sustained attendance at work for people to be categorized as employed" (Marwaha and Johnson, 2004, p. 338). They found a rate of employment between four percent and 60%, with most of the studies before the 1990s reporting a rate of 20% to 30% in the United Kingdom. The rate of employment among people with schizophrenia in the United States ranges from three percent to 42.8%, with *The Sixteen-State Study on Mental Health Performance Measures* (Geertsens et al., 2002) showing statewide competitive employment rates of people with schizophrenia of being between three percent and 18%. Similar figures were found in all clients with severe

mental illness in a 10-community health center study in New Hampshire (Drake et al., 1998).

Variations over time in the employment rate among people with schizophrenia and among the general population in the United Kingdom were plotted for 50 years by Marwha and Johnson (2004). There are various caveats by the authors on interpretation of this data, one being that the employment rate has decreased for men in the general population while increasing for women in the period studied. Another caveat is the change over these years of the demand in the United Kingdom for manual workers such that the government encouraged immigration. Also cited was an increasing emphasis on productivity and service industries.

As for the barriers to employment faced by individuals with schizophrenia, Marwha and Johnson (2004) are in agreement with Rutman (1994). Stigma is commonly referred to by people with schizophrenia as being the biggest barrier to finding and keeping work in the United Kingdom, similar to the United States. Another barrier is worry over benefits. In interviews with a large number of service users regarding their employment needs, fully 70% of those not interested in working claimed worries over benefits as an aspect of their reasoning for being uninterested (Secker, Gove, and Seebohm, 2001).

Other Factors Associated With Employment

Rogers and Kegan (1991) found being married was associated with having a job, whereas Drake, Fox, Leather, Becker, Musumeci, Ingram, and McHugo (1998) found

rural areas tended to have higher rates of employment. Marwha and Johnson (2004) further found that measures of premorbid functioning were no better than previous work history in predictive value of future employment. Negative symptoms have been found to be associated with unemployment both cross-sectionally (Solinski, Jackson, and Bell, 1992) and prospectively (Johnstone 1991; Lysaker and Bell, 1995).

Lack of Services

Vocational rehabilitation is often not included in the care plans of people with schizophrenia (Lehman et al., 1998), and this lack of services may reflect low expectations among professionals. Secker et al. (2001) found 53% of the people who said they wanted work had not received help from vocational services. Unmet needs for support in the workplace were also identified by Basset, Lloyd, and Basset (2001). A particular service that consumers wanted were programs which assisted them in time and stress management and in developing problem-solving skills in the workplace (Marwha and Johnson, 2004).

Is there evidence that employment can influence other outcomes in schizophrenia? Marwha and Johnson (2004) concluded that employment may improve the quality of life in individuals with schizophrenia. Eklund, Hansson, and Bejerholm (2001) found job satisfaction had a strong relationship with quality of life. Others reported a significant association (Arns and Linney, 1993) although this effect may be related to self-esteem, a factor that is itself correlated with employment outcome (Brekke, Levin, Wolkon, Sobel, and Slade, 1993).

Marwaha and Johnson (2004) noted that unemployment in people with schizophrenia has increased in the United Kingdom during the past 50 years. They listed the interplay between barriers which people face, social and economic factors, and the incentives for people with schizophrenia as the likely reasons for the declining rate of employment for these people in the United Kingdom. Furthermore, they recognized an influence over other types of social outcome, clinical benefits, increased self-esteem, and better quality of life as a result of employment (Marwaha and Johnson). These possible outcomes could be quite encouraging for individuals who suffer from schizophrenia and seek employment. However, the finding that the unemployment rate for people with schizophrenia has increased over the past 50 years in the United Kingdom has not been replicated in the United States.

Summary

Unemployment for people with schizophrenia or schizoaffective disorder is an ongoing problem in the United States and in other countries around the world. Evidence exists that researchers throughout the world are attempting to find ways to improve employment among members of this population. The current study attempted to contribute to the knowledge base concerning possible remedies for this ongoing social concern.

Schizophrenia is a disorder that affects people in many areas of their life. Reasons for the high rates of unemployment for those afflicted have been offered by various researchers. However, none of the studies reviewed focused on the processes which those

individuals who are employed found to be beneficial in both obtaining and maintaining employment. This is a gap in the literature that the present study has sought to fill.

CHAPTER 3: METHODOLOGY

This study was qualitative in nature with an emphasis on understanding the processes used by people with schizophrenia or schizoaffective disorder in returning to or initially securing employment after diagnosis. Interviews were used to gather data. The data consisted of the thoughts and perceptions of those individuals. Thematic analysis was ongoing during data collection and transcription.

Phenomenology

Through various readings of qualitative theory, I locate myself in the phenomenological tradition of Edmund Husserl (Creswell, 1998; Marshall and Rossman, 1995; Moustakas, 1994; Osborne, 1994; Patton, 1990; Polkinghorne, 1989; Rice and Ezzy, 1999) as a researcher. This tradition posits that only the data which are available to consciousness are useful and certain. It seeks to determine the essence of a phenomenon (e.g., what processes are inherent in the return to or initial securing of employment among persons with schizophrenia or schizoaffective disorder). Finding this essence requires examination of firsthand accounts of what is conscious to those who have experienced the phenomenon. The thoughts and perceptions of these people are a distinct part of consciousness of an experience. I endeavored to understand these thoughts and perceptions via audio-recorded interviews with people with schizophrenia or schizoaffective disorder.

Epoche

In preparing for and executing these interviews, I engaged in the process known as epoche. *Epoche* is a “Greek word meaning to stay away from or abstain” (Moustakas,

1994, p. 85). In epoche, the researcher sets aside presuppositions, preconceptions, and biases about the phenomenon of study. This is accomplished by an openness of the researcher's consciousness to whatever or whoever appears there and seeing only what is actually there, while allowing it to linger. In other words, the researcher is transparent to himself or herself to whatever appears in his or her consciousness and sees it with new eyes in a naïve and totally open manner (Moustakas, 1994).

Furthermore, epoche is a method which precedes reflectiveness, judgments, and conclusions and allows what is there to stand as it appears (Moustakas, 1994). Husserl (1970) stated that in epoche we "seek to attain the beginnings in a free dedication to the problems themselves and to the demands stemming from them" (p. 115). In practice, everything which appeared in my consciousness regarding the phenomenon of returning to employment after a diagnosis of either schizophrenia or schizoaffective disorder became available for self-referral and self-reevaluation. To further enable unbiased interpretation of data, triangulation was used when available.

Triangulation

Triangulation in qualitative research refers to enhancing the quality of data by gathering information from multiple sources in multiple ways to "illuminate different facets of situations and experiences and help to portray them in their complexity" (Popay, Rogers, and Williams, 1998, p. 348). Furthermore, triangulation permits a comparison and convergence of corroborating and dissenting accounts of a phenomenon, allowing a greater examination of the varied aspects of the research topic (Fossey, Harvey, McDermott, and Davidson, 2002). I asked each participant after the first interview if

there were any documents or other materials concerning his or her return to or initial obtaining of employment that he or she would like to share with me that could aid in my obtaining a richer understanding of the processes he or she experienced. Those who chose to share documents or materials assisted in this aspect of triangulation of the interviewee data. To further aid in triangulation of the participant's interview data, I asked all participants if there were any members of their formal or informal support system that they thought could further aid in a more thorough account of the processes that the participant experienced. Five of the eight participants themselves chose to share some of their informal support systems' interpretations of their unique experiences. A further aid to triangulation was the use of the Andresen et al. (2003) stage model of recovery, the Jacobsen and Greenley (2001) model of recovery, and the Spaniol et al. (2002) evolution of phases of recovery as templates in the development of research questions. The answers to these questions helped to triangulate the data gathered with the existing literature on recovery from schizophrenia or schizoaffective disorder. Triangulation was also achieved through the pre-interview questions asked of each respondent during the initial telephone conversation. These pre-interview questions established that the eight respondents met criteria for the study. A copy of these pre-interview questions is included in the appendix. The criteria were taken from the Russinova et al. (2002) study found in the literature on employment among individuals with schizophrenia or schizoaffective disorder. Also, comparison of dissenting and corroborating accounts of a phenomenon involves aspects of the researcher's personal experiences with the research topic. These personal experiences of the researcher added another layer to the triangulation process.

The Researcher

I have schizoaffective disorder. My interest in employment of people with schizophrenia or schizoaffective disorder began with my personal experience of attempting to maintain employment after my initial diagnosis of brief psychotic episode in 1989.

I found it very difficult to hold a position of employment for the first four years after my initial psychotic break. I tried various fields and levels of employment, all with similar results: within six months, a relapse of the illness and a loss of employment. In 1993, I had the worst episode of my life and applied for Social Security disability. My claim was approved and I slowly began the process of recovery. In 1998, I returned to graduate school. I received a master's degree in Community Agency Counseling in August of 2000.

I am currently working as an outpatient mental health therapist at a local community mental health center. In this position, I have occasion to encounter people with schizophrenia or schizoaffective disorder. I have found them to have similarities in symptoms of their respective illnesses and a wide variety of unique aspects of their personalities and experiences. It was my intention to give voice to similar people by the use of three semi-structured interviews, each lasting approximately one hour.

As stated previously in reference to epoche, I intended to constantly and conscientiously be critical of as many preconceptions, assumptions, or prejudgments I brought to the study as possible. One of the preconceptions that I recognized regarding this phenomenon before collection of data was the belief that the work ethic is something

that all people should have. On self-reflection and focused contemplation, I realized that not all people have, desire, or need a similar work ethic. Furthermore, I am not an authority on what people should do in their lives; that would be a value judgment. Another assumption that I came to realize as being such is that people with schizophrenia or schizoaffective disorder have the ability, capacity, or desire to achieve goals of employment that some people, such as I, have achieved. I now recognize this as an assumption that could have limited my objectivity toward this population.

By engaging in *epoche*, I recognized these potential biases and began to move from my natural attitude (i.e., the habituated manner in which I experience the world) to a deeper understanding of my assumptions (Osborne, 1994). I did follow Spiegelberg's (1982) suggestions in the *epoche* or *bracketing* process. According to Spiegelberg, bracketing is a term synonymous with *epoche*. There are two stages to the bracketing process. The first is eidetic reduction. This stage involves data reduction to the point of defining its essential structures and elements. Phenomenological reduction proper, the second stage, involves a suspension of the researcher's natural standpoint, enabling the phenomenon to be untainted by the researcher's conditioned distortions (Cohen and Omery, 1994; Moustakas, 1994). This process requires the researcher to set aside theories pertaining to the object while not allowing himself or herself to disbelieve the same in an accommodation of descriptive inquiry (Klein and Westcott, 1994; Osborne, 1994). This bracketing process (*epoche*) was ongoing and continued throughout the research procedure.

Participants

The participants in this study were eight people who have been diagnosed with either schizophrenia or schizoaffective disorder within the last 25 years, have not been hospitalized within the last year, and have been employed for at least six months in the past two years. A further criterion is that they worked for at least 10 hours per week during the six-month period. These criteria are in concert with existing research concerning the employment of people who are psychiatrically disabled (Rusinova, et al., 2002).

Rusinova et al. (2002) operationally defined stability of workforce participation as 10 hours of work per week for at least six months over the past two years. The 10-hour-per-week work threshold is consistent with the Social Security Administration's requirement for a trial work period. The manner in which the participants in the current study were selected was in response to a flyer describing the study which was posted in four outpatient mental health centers in a Midwestern state and an e-mail advertisement posted on the web site of the National Alliance on Mental Illness in a Midwestern state. Samples of the flyer and email advertisement are included as Appendix C and D, respectively. This type of sampling is well established in the qualitative research literature as being purposive, meaning that people were deliberately selected to provide important information pertaining to this phenomenon (Maxwell, 1996; Morse, 1989).

Each respondent was asked if he or she could provide the names of others who have had similar experiences. This technique is known as snowballing (Luborsky and Rubinstein, 1995) and refers to known informants providing names of potential

informants with similar experiences. This technique provided additional informants who provided rich descriptions of the phenomenon (Osborne, 1994; Polkinghorne, 1989). One possible limitation with snowballing is the loss of anonymity between informants. This possibility was discussed with each respondent during the first interview. Another possible problem with snowballing is that it relies on the respondents' social networks and tends to result in a homogenous sample (Rice and Ezzy, 1999).

Those who responded to the postings and met the criteria as determined by the researcher in a telephone pre-interview after they contacted the researcher were scheduled to have the first interview at a time and place mutually agreed on. Before the first interview, each respondent read and signed a letter of informed consent which explained the study in detail and informed him or her of the legal right to knowingly participate and withdraw at any time during the study without penalty of any kind. A copy of the Ohio University Institutional Review Board (IRB) approved informed consent document is listed in Appendix E. When I received the signed informed consent form, the interviews began. At the beginning of this first interview, the respondent was assured that a numeric code known only to the researcher would be generated to protect his or her anonymity. No names were connected to any interview data and all interviews were identified by the numeric codes. These codes were determined by the participant's gender, interview number, and location of interview. The indentifying information for this coding was kept in a locked file cabinet in my office. It was destroyed at the end of the study.

Qualitative Clarity

The concept of qualitative clarity as described by Luborsky and Rubinstein (1995) guided my sampling for meaning of the experience of an individual returning to employment after a diagnosis of either schizophrenia or schizoaffective disorder. This concept is defined as including two components: grounding and sensitivity to context. Grounding involves evaluation to assess if adequate numbers of conceptual perspectives have occurred in a study enabling a variety of meanings to be identified. Grounding further involves the ability to critique multiple interpretations of meanings. Sensitivity to context involves the researcher demonstrating how the methods and styles of analyses have been “influenced by cultural and historical settings of the research in order to keep clear whose meanings are being reported” (Luborsky and Sankar, 1993, p. 442).

I partially achieved qualitative clarity by interviewing both men and women of differing socioeconomic backgrounds, educational levels, and marital statuses. These participants helped ensure that adequate conceptual perspectives were obtained by gaining a heterogeneous sample in regard to demographics. Although all participants now live in the same Midwestern state, two lived in Europe for approximately six years of their lives, two lived in other Midwestern states for a large part of their lives, and one lived in a major west coast metropolitan area for approximately two years. These varied cultural experiences in the lives of five participants also enhance qualitative clarity through the sensitivity to context which I recognized as being a part of each participant's unique life experience.

Historical sensitivity to context was a factor in the analyses of the participants' transcripts by my recognition that the age of the participant partially influenced how he or she viewed the phenomenon of returning to employment following diagnosis. Qualitative clarity was further enhanced by interviewing eight participants and recognizing that no new themes were emerging in the final two interviews.

Demographic information was obtained during the first interview session before any audio-recording of data. The information gained from the demographic questionnaire was important for obtaining possible differing perspectives and conceptual themes related to gender, marital status, ethnicity, educational level, age, and socioeconomic level. The form for gathering the demographic data is presented here and also in Appendix A.

1. What is your gender? Male___ Female___
2. What is your marital status? Single___Married___Divorced___Widowed___
Partnered_____
3. What is your ethnicity? White___African American___
Hispanic___American Indian___ Asian___ Other___
4. What is your educational level? K-8___high school___college___post-
graduate work ___post-graduate degree___
5. What is your approximate age? 18-25___25-35___35-45___45-55___
65-75___75 and above___
6. What is your annual income? Less than \$10,000___
\$10,000-14,999___\$15,000-19,999___\$20,000-24,999___
\$25,000-29,999___\$30,000-34,999___\$35,000-39,999___

\$40,000-44,999__\$45,000-49,999__\$50,000-59,000__
 \$60,000-64,999__\$65,000-69,999__\$70,000-74,999__
 \$75,000-79,999__\$80,000-84,999__\$85,000-89,999__
 \$90,000-94,999__\$95,000-99,999__Over \$100,000__

This information further helped assure qualitative clarity and aided in thematic analysis of differing experiences related to employment levels.

Sampling within the data is another important aspect of qualitative clarity according to Luborsky and Rubenstein (1995). This involves examining the entire set of qualitative materials while refraining from looking selectively for certain parts of the text which confirm and describe only a particular finding. In other words, I remained open to a variety of possible interpretations and analyses of the data.

Another component of qualitative clarity is similar in definition to the process of epoche described in the introduction of this chapter. This component of clarity involves an awareness and critical review of the context and theories I introduced in the sampling and in data analysis (Luborsky and Rubenstein, 1995).

Method

The method used was semi-structured interviews of the participants. Semi-structured interviews were used as a necessary framework for the initial interview, which allowed for rapport-building conversation and facilitated open-ended discussion in later interviews. Structured interviews could have led to a less open-ended type of response from the interviewee because of the potential for the interviewee to give limited information to more specific formalized questions.

Three interviews lasting approximately one hour each were conducted with each participant. However, if the participant desired to talk longer, he or she was encouraged to do so. A series of questions was used to prompt the individual. Each person was encouraged to expand on the topics he or she deemed important. A list of these questions is included in Appendix B and the following section.

Questions and Rationale

The questions were developed from previous research which suggests this additional information may be helpful and even necessary to those working with people with schizophrenia or schizoaffective disorder (Andresen et al., 2003; Jacobsen and Greenley, 2001; Spaniol et al., 2002). The stage model of recovery by Andresen et al. (2003) was used as a partial guide in the development of the questions. This is a five-stage model developed by analyzing a pattern in the qualitative studies they researched (Baxter and Diehl, 1998; Davidson and Strauss, 1992; Pettie and Triolo, 1999; Spaniol et al., 2002; Young and Ensing, 1999). It consists of the following stages: moratorium, awareness, preparation, rebuilding, and growth. Furthermore, the questions listed were developed with a view toward the findings of Spaniol et al., (2002) in a qualitative study of 12 people with a diagnosis of either schizophrenia or schizoaffective disorder. That study was conducted over a period of four years and included interviews with the respondents. The researchers in that study found three broad phases: overwhelmed by, struggling with, and living with the disorder. As the people moved through these phases, they were faced with the tasks of seeking an explanation for their experience, trying to

control the illness, and attempting to establish themselves in productive roles (Spaniol et al.).

Jacobsen and Greenley (2001) developed a model of recovery which incorporated internal and external conditions. Internal conditions included attitudes, experiences, and the process of change, whereas external conditions consisted of policies and practices which aided recovery. I endeavored to incorporate most of these aspects of recovery found in the literature in the following questions asked during the first interview.

1. *What does recovery mean to you?* This initial question sought to determine whether the individual had a similar concept of recovery to that found in the recovery literature cited. A possible concept was the one suggested by Andresen et al. (2003) in the second stage of the five-stage recovery model – the stage known as awareness. It was possible that the individual had his or her own unique interpretation of the concept.
2. *Has that changed over time?* This question sought to engage the respondent in a discussion of his or her thoughts and feelings as to the possible evolution of the recovery processes he or she may have encountered or the similarity with the awareness stage. If similar to the awareness stage, his or her recovery process is probably consistent with the five-stage model of recovery and lends credibility to the model by providing probable evidence which the participants may have experienced this stage of recovery. The awareness stage of recovery involves an awareness by the individual of a possible self other than that of a sick person—a self that is capable of recovery. This question had the further possibility of corresponding to the Spaniol et al. (2002) evolution of phases.

3. *Did you have any supports in returning to employment? What were they?*

These questions sought to determine whether the individual had an organized, informal, or nonexistent support system, also related to the awareness stage of recovery in which an individual's recovery can be sparked by a clinician, a significant other, or a role model. Furthermore, in an indirect manner it addresses the Jacobsen and Greenley (2001) external condition of policies by seeking to understand if the individual was supported by public agencies, for example.

4. *Did you have any services in returning to employment?* This question is a further refinement of the support question expressed in Question #3.

5. *Do you take any medications for your mental illness? If so, do you take the medications regularly?* These two questions sought to determine whether participants took medication for mental illness regularly. Research suggests that medication compliance reduces positive symptoms of both schizophrenia and schizoaffective disorder in from 50% to 85% of those afflicted with either disorder (Lehman et al., 1998).

6. *How did you identify services available to you?* This question sought to determine whether and how services were identified in the individual's reemployment. Furthermore, it can be of benefit to people working with this population in a greater understanding of the effectiveness of identification of services by people with either schizophrenia or schizoaffective disorder (Anthony, 1994).

7. *Did anyone assist you in returning to employment? Who?* These questions sought to determine whether the individual had a person who assisted him or her in reemployment. They also reflected possible aspects of the third stage of

recovery known as preparation. In this stage of the Andresen et al. (2003) model of recovery, aspects of learning about mental illness and becoming involved in groups and connecting with peers are prevalent. Furthermore, it sought to address two phases of the Spaniol et al. (2002) model, the struggling with and living with phases, by attempting to control the illness through assistance from others and attempting to establish oneself in a productive role.

8. *If you have a support system, did it have an influence on your decision to return to work?* This question attempted to elicit a response as to potential influences of others on the individual's decision to return to employment, also reflected in the preparation stage of the recovery model of Andresen et al. (2003).
9. *What has been your experience with your employer?* This question invited an open-ended discussion of positive or negative aspects of the relations between an employee with a disability and his or her employer. Furthermore, answers to this question could aid in the retention of people with schizophrenia or schizoaffective disorder in employment through a greater understanding of how a person with a disability relates with his or her employer (Anthony, 1994).
10. *Were there any problems with your employment? What? What did you do?* This series of questions invited an open-ended discussion of decision-making and problem-solving skills used by the respondents in their day-to-day experiences of being employed. Furthermore, it addressed aspects of the

fourth stage of recovery in the recovery model – the rebuilding stage, in which the hard work of recovery takes place according to Andresen et al. (2003). It involves taking responsibility for managing one's illness and taking control of one's life. It involves taking risks, suffering setbacks, and coming back to try again.

11. *Did you experience failure at any time during your attempt to return to employment? How did it affect you?* These questions also sought further information regarding the rebuilding stage of recovery of the Andresen et al. (2003) model.
12. *How do you handle stress at work?* This question sought a discussion of coping skills related to employment and sought to determine if the individual had reached the fifth and final stage of the recovery model of Andresen et al. (2003) termed growth. In this stage, the individual knows how to manage the symptoms of his or her illness and has resilience in the face of setbacks and a positive sense of self and looks forward to the future regardless of setbacks, such as a stressful day.

These questions were a preliminary guide to an open discussion concerning the phenomenon of returning to employment after diagnosis of schizophrenia or schizoaffective disorder. In keeping with the emergent design of phenomenological qualitative research, further questions were developed as the study proceeded and the researcher became more conversant with each individual.

The emergent process of analysis of qualitative research involves an openness of the researcher to anticipating the revision of preliminary interview questions as additional data were generated in the field. It can involve various aspects of the research that were not entirely evident during the planning or implementation of the study (Bogdan and Biklen, 1998).

A professional transcriptionist wrote down the audio-recordings. Before analysis began, I compared the recordings to the transcripts to verify the accuracy of the transcripts. Each participant was sent a copy of his or her transcript to verify that it correctly and accurately represented his or her thoughts. If a participant believed that the transcript was inaccurate, he or she could make changes to the transcript and return it to me. This process is termed *member checking* (Fossey et al., 2002). The participant's involvement in the research process aids in the transparency of the research. The transparency of research descriptions allow the reader to discern "whether and how competing accounts within the data were explored and interpreted, and how the researcher's thinking contributed to the analysis" (Fossey et al., 2002, p. 729).

Any type of documentation which an individual believed to be meaningful to the researcher's understanding of his or her experiences was examined and photocopied with the participant's permission. Such documents aided in triangulation of the oral data gathered during the interviews.

Analysis of Data

I began analysis of the data using the van Kaam (1966) method of qualitative analysis by actively listening, observing, and thinking about the meaning of the

respondents' accounts in the data as they were collected. I kept written field notes of my initial reactions and reflections of each interview. These field notes further described the people, places, activities, and conversations which took place and aided in my ability to keep track of the overall development of my project while allowing for a personal awareness of how I was being influenced by the data (Bogdan and Biklen, 1998). I then developed labels for these meanings.

The purpose of labeling meanings was for use as an aid in the van Kaam (1966) method of qualitative analysis. Method labels were a part of the invariant constituents which were core themes of the data collected (Moustakas, 1994). Concerning validation of these labels, I asked the respondents whether the labels accurately described the data during the second interview. This was a further aspect of member checking described by Lincoln and Guba (1985) and can facilitate a greater understanding of the phenomenon by the researcher through the validation of participant's interpretation of the data.

I concluded that the essence of the phenomenon is discernable through the van Kamm (1966) method of analysis. The van Kamm method involved horizontalization or a listing of every expression found in the transcript which is relevant to the process of returning to employment after a diagnosis of either schizophrenia or schizoaffective disorder. Next, irrelevant or repetitive data were reduced and eliminated to determine invariant constituents. These constituents were expressions which contained a necessary and sufficient constituent for understanding the phenomenon, and they were tested for those components. A necessary and sufficient constituent contained a moment of the experience which was vital to the understanding of the experience. Furthermore, it was

possible to abstract and label the constituent, and it was determined to be a horizon of the phenomenon and was retained. If it did not meet this necessary and sufficient test, it was eliminated. Also eliminated were overlapping, vague, and repetitive expressions which could not be presented in more descriptive terms. What remained were the invariant constituents. A clustering of the related invariant constituents commenced with the goal of developing thematic labels of the experience. These clustered and labeled constituents formed the core themes of returning to work after a diagnosis with either schizophrenia or schizoaffective disorder (Moustakas, 1994).

The next step in the van Kamm (1966) method was a check of the invariant constituents and themes against the original interview transcript for validation. If they were not explicit and compatible with the respondents' experience, they were eliminated. A further development of the relevant, validated invariant constituents and themes was a construction of an individual textural description, which included verbatim examples of the transcribed interview for each respondent (Moustakas, 1994). I used imaginative variation and the individual textural description, and I constructed an individual structural description. Imaginative variation involves an emphasis on meanings and essences and moves away from facts and measurable entities; it involved reflective phases in which numerous possibilities were examined and explicated.

Next in the van Kamm (1966) method of analysis was a construction of a textural–structural description of the essences and meanings of the return to work for each respondent, including the invariant constituents and themes. I looked for words and phrases which could be placed in categories, then analyzed these words and phrases and

determined whether they could be combined under certain themes. Finally, a composite description of the meanings and essences of the return to work that represent the group as a whole was developed from the individual textural–structural descriptions (Moustakas, 1994).

I read through the data several times in an effort to immerse myself in the data (Cohen, Kahn, and Steeves, 2000). This immersion is considered a process in which most, if not all, attention and thought is directed toward understanding nuances of the data that were not apparent on primary, secondary, or even tertiary readings. My goal in the immersion process was an initial interpretation which helped guide the clustering and thematizing of the invariant constituents in later analysis. In this phase (immersion), I discovered the essential characteristics of each interview.

Analysis then proceeded to data transformation or data reduction. In this phase, I made decisions regarding the relevancy of the data. Obvious topical digressions and language errors were eliminated without changing unique characteristics (Cohen et al., 2000). Line-by-line thematizing then proceeded with the reduced chance of losing essential meanings of the data. This is termed in the van Kaam (1966) stage method of data analysis *reduction and elimination* to determine invariant constituents (Moustakas, 1994).

Thematic analysis was the next phase, whereby phrases in the text were underlined with tentative theme names written in the margins of the text. I examined the text line by line and labeled important phrases with tentative theme names (Barritt, Beekman, Bleeker, and Mulderij, 1984). Passages with similar theme names were cut out

of the text, and piles were made of those with similar labels. These steps aided in the validation and final identification of the invariant constituents and themes. I next did a content analysis and classified the statements and themes. Groups of text were subdivided with an eye toward locating exemplars; “exemplars are defined as bits of textual data in the language of the informant that capture essential meaning of themes” (Cohen et al., 2000, p. 80).

Subthemes were found to exist in the analysis of major themes. These subthemes were divided and categorized when it was determined through analysis that they contained aspects of the experience of the major theme. As I gained insight into the informants’ experience through exemplars and in the themes, I summarized my understandings in written memos which helped in the transformation of the field text into the narrative text (Steeves and Kahn, 1994). The overall analysis I did was a content analysis of the transcripts to identify concepts and categories that emerged from the text.

The writing of the narrative text commenced with constant reference to the written memos and use of quotations juxtaposed with my interpretations and descriptions. This type of process helped ensure that the reader encounters an authentic representation of the participant’s voice while enhancing the permeability of my role. Permeability refers to evidence which I learned from the research encounter.

Summary

This chapter described how the present phenomenological study was conducted. It also describes the researcher and his use of epoche throughout the study to remain as bias-free as possible. The van Kaam (1966) method of analysis was used and has been

described with the specific terminology of the method offered. Qualitative clarity has been attempted and has also been discussed. The overall purpose of this chapter has been to describe how the study was developed, executed, and analyzed. To that end, the process from the selection of phenomenology to writing of the narrative text has been described.

CHAPTER 4: RESULTS

This chapter describes the results of the data collected from the eight participants in this study. It begins with descriptive data and proceeds to the results from the research questions posed to the participants. Also, results from questions which emerged during each interview which were not apparent prior to the interviews or prior to data analysis will be presented. The foundation for interpretations, conclusions, and recommendations made in chapter five are laid out in this chapter.

Descriptive Data

The participants in his study were six Caucasian males and two Caucasian females. The participants who were interviewed represent a limited degree of both ethnicity and cultural diversity. Gender, age range, socioeconomic level, marital status, and education level were somewhat diverse. However, the participants represent a homogenous sample in their ethnicity. Gender, marital status, socioeconomic level, and educational level data are presented in Table 1, which shows the difference in the participants involved in the study. As can be seen in Table 1, the greatest difference is gender and socioeconomic level. Slight differences are present in the age range of participants and their education levels. Differences in the interview data collected became most apparent during the analysis stage of the study.

Table 1

Demographic Information

| Gender | Age Range and Marital Status | Socioeconomic Level | Education |
|----------|------------------------------|---------------------|---------------------|
| Female 1 | 25-35 Single | \$10,000-14,000 | Two Years College |
| Female 2 | 18-25 Single | \$15,000-19,999 | Three Years College |
| Male 1 | 35-45 Single | \$0-9,999 | Associate's Degree |
| Male 2 | 35-45 Married | \$15,000-19,999 | High School Grad |
| Male 3 | 35-45 Single | \$10,000-14,999 | Two Years College |
| Male 4 | 25-35 Married | \$15,000-19,999 | Bachelor's Degree |
| Male 5 | 45-55 Married | \$60,000-64,999 | Master's Degree |
| Male 6 | 45-55 Divorced | \$65,000-69,999 | Bachelor's Degree |

Seven participants attended college for at least two years. The second female was attending college at a major Midwestern university. Male 2 received a high school education. Each female and three male participants were single. Male 6 was divorced and had the highest income. Male 5 held a master's degree and had the second-highest income. Further descriptive data are presented in Table 2.

Table 2

Participant Employment and Medication Information

| Participant | Current Employment | Type of and Employment | Years of Employment | Medication Compliant | Type of Antipsychotic |
|-------------|------------------------|----------------------------|------------------------|-------------------------|--------------------------|
| Female 1 | Part-Time | Retail | 3 | Yes | Atypical |
| Female 2 | Full-Time | Mental Health | <1 | Yes | Atypical |
| Male 1 | Part-Time Volunteer | Mental Health | 6 | Yes | Atypical |
| Male 2 | Full-Time | Retail | 1 | Yes | Typical |
| Male 3 | Part-Time | Mental Health Volunteer | 3 | Yes | Atypical |
| Male 4 | Full-Time | News | 7 | Yes | Atypical |
| Male 5 | Full-Time | Computer Programming | 17 | Yes | Atypical |
| Male 6 | Part-Time | Volunteer Disability | 3 | Yes | Typical |

As Table 2 indicates, Males 1, 3, and 6 all worked part-time and Males 1 and 3 had a combination of paid and volunteer work. Male 6 volunteered exclusively and received disability payments through the Veterans Administration. Males 2, 4, and 5 all worked full-time in the retail industry, news media, and computer programming field, respectively.

Female 1 worked part-time in the retail industry, while Female 2 had recently begun full-time employment in the mental health field. All participants were medication-compliant with six of the eight prescribed atypical antipsychotics. Males 2 and 6 were prescribed and taking typical antipsychotics. The number of years employed varied within the range of less than one year to 17.

It should be noted that Male 3 was dually diagnosed with polysubstance dependence in remission at the time and undifferentiated schizophrenia. Female 1 also had a dual disability of undifferentiated schizophrenia and vision impairment.

Categories

Content analysis of the transcripts allowed categorization of the contents of the research and additional questions which were developed in the field. Six categories emerged through repeated reading of all transcript data and the use of the van Kamm (1966) method of data analysis. Specifically, these categories were partially developed as the interviews were occurring and I was taking written notes. They were further developed by testing each potential category against the interview transcripts to determine if they expressed the general concepts which were consistent with each participant's statements.

Table 3

Categories List

 Self-help

Employment

Assistance with employment

Benefits of employment

 Functioning at a perceived normal level while living as full a life as possible with the
 illness

 Recovery to employment

The six categories that emerged from this study were as follows: (a) self-help, (b) employment, (c) assistance with employment, (d) benefits, (e) functioning at a perceived normal level while living as full a life as possible with the illness, and (f) recovery to employment. These six categories led to the sub-themes listed in Table 3, which, in turn, led to the themes also listed in Table 3. Also listed in Table 3 are the frequencies of the sub-themes and themes which were determined through content analysis.

Table 4

Frequency of Theme and Sub-Theme Information

| Theme | Frequency | Subtheme | Frequency |
|-----------------------|-----------|---------------------------------------------------|-----------|
| Self-care | 8/8 | Medication compliance | 8/8 |
| | | Stress reduction | 7/8 |
| Employment issues | 8/8 | Approaching employment gradually and carefully | 6/8 |
| | | Stigma | 3/8 |
| | | Disclosure of condition | 6/8 |
| | | Formal accommodations | 2/8 |
| | | Change of employers due to problems of disability | 3/8 |
| | | Lack of failure | 8/8 |
| Supports | 8/8 | Family and friends | 7/8 |
| | | Governmental supports | 4/8 |
| | | Private supports | 4/8 |
| Rewards of employment | 8/8 | Intrinsic rewards | 5/8 |
| | | Extrinsic rewards | 3/8 |
| Recovery process | 8/8 | Developmental process | 8/8 |
| | | Normalcy | 8/8 |

Table 3 displays the five general themes and their frequency of occurrence which content analysis of the transcripts revealed. The a/b frequency column shows how many participants (a) out of all participants (b) were found to be congruent with that theme or subtheme.

Research Questions Results

The following 12 research questions and examples of the results appear below:

1. *What does recovery mean to you?* The responses to this question varied slightly; however, a common answer was living as normal a life as possible with the limitations that were present due to each individual's particular illness. As was expressed by Male 6, "To me, recovery is doing the best you can given whatever limitations and abilities you have as a result of your personal life and your mental illness; and just basically, you're doing the best you possibly can." Male 6's answer and others led to a sub-theme of normalcy under the main theme of recovery process.
2. *Has that changed over time?* The participants cited learning about themselves and their illnesses as being a developmental process in their recovery. All participants' experiences with recovery could be placed in the awareness stage of the Andresen et al. (2003) stage model of recovery. Male 1 responded to this question by stating, "Not really; no. It just all comes down to those annoying hallucinations. Trying to get stuff done and voices saying things." Male 2 responded this way: "I just felt like I couldn't function half the time. I was lazy and I didn't do nothing." In response to this question, the analysis revealed the four remaining male participants suggested a developmental sub-theme to their concept of recovery. They spoke of changing

priorities throughout their recovery and learning more about themselves in relation to their illnesses. Female 1 did not directly respond to this question, while Female 2 stated that her concept of recovery has not really changed since she was diagnosed with schizoaffective disorder.

3. *Did you have any supports in returning to employment? What were they?* The results from these questions revealed that more than half of the participants reported their family and friends as being their primary source of support in returning to work. Family and friends was a sub-theme under the main theme of supports. Other sub-themes that were revealed through analysis were governmental supports and private supports. Three of the participating males and both of the females listed their families as an essential source of support in returning to employment. One male listed personal contact with the mental health community he was once a part of as being essential in his gaining of employment in that field. Two males cited government services as being instrumental in their return to employment.
4. *Did you have any services in returning to employment?* This question is an extension of the support question #3. Half of the participants received formal support services from either state government agencies or federal government programs in their present employment.
5. *Do you take any medications for your mental illness? If so, do you take the medications regularly?* All participants stated that they took medication regularly for their mental illness. Medication compliance was a sub-theme under the main theme of self-care.

6. *How did you identify services available to you?* Answers revealed that identification of service availability came through either personal contacts or through mental health and Armed Services agencies.
7. *Did anyone assist you in returning to employment? Who?* The answers to these questions are also consistent with both the Andresen et al. (2003) preparation stage and the “struggling with” and “living with” phases of the Spaniol et al. (2002) model. The majority of participants listed family and friends as being their main source of assistance in returning to employment through encouragement and contacts known to their parents. Only Female 2 related that she looked for employment on the Internet, found the opening at her current job, went there, and applied.
8. *If you have a support system, did they have an influence on your decision to return to work?* Male 1 gave this response: “Mom and Dad are very, I dare say – no way would they put up with me sitting around and watching TV all day. No way. So yes, they are very much an influence on my work ethic.” Two other males also cited their families as being a vital influence on their decision to return to work, as did both female participants. Male 3 stated his friends in the mental health community were his major influence to returning to employment, while Male 5 gave no credit to any person as being influential to his decision, similar to Male 6. The majority of the participants listed families or friends as being influential in their decision to return to employment.

9. *What has been your experience with your employer?* The majority of participants (six of eight) expressed positive experiences with their current employers as of the dates of their final interviews for this study. For example, Female 2 stated that “everyone I work for seems so understanding of mental illnesses.”
10. *Were there any problems with your employment? What? What did you do?* The results from these questions revealed that half of the participants had no problems with their employers as of the date of the final interview. The remaining half either changed employers as a remedy or chose to receive full disability benefits.
11. *Did you experience failure at any time during your attempt to return to employment? How did it affect you?* The results revealed a relative lack of failure in the employment arena of the participants studied. Also, results showed prior failures that were dealt with by seeking and gaining other employment. Results also reveal that at some point in their respective recovery process, all participants could be found to have gone through the rebuilding stage of the Andresen et al. (2003) model. For example, Male 2 was terminated as a stockperson at a supermarket for not working at the speed which the management preferred. Male 2 sought employment elsewhere and did not give up on finding a position that he was able to maintain. Female 1 had similar experiences in her efforts to find and maintain employment. She spoke of three positions she attempted to maintain but she did not work fast enough to keep up with the other employees. Despite these setbacks, she persevered and found a position that was right for her. Both of these

individuals went through the rebuilding stage by suffering these setbacks and continuing to come back and try again.

12. *How do you handle stress at work?* Results revealed cognitive and behavioral techniques which each individual used to cope with workplace stress. This could be related to the growth stage of the Andresen et al. (2003) model due to the ability of all to manage the symptoms of their illnesses and also have a positive sense of self. In this stage, the individual knew how to manage symptoms of his or her illness and had resilience in the face of setbacks, had a positive sense of self, and looked forward to the future regardless of setbacks, such as a stressful day. All were optimistic regarding their futures. An example is Male 3's assertion that he was striving to become an author of fiction novels. He was very much convinced that this would occur in the future. Another example is Female 1. She had a very optimistic attitude concerning her future despite what most people would consider to be setbacks in the employment arena. She was planning on becoming more self-sufficient than at the time of the final interview.

Supplemental Findings of Additional Questions

As each interview progressed, questions which were not immediately obvious prior to starting the interview became apparent. Some of these questions were unique to each individual and his or her experience with recovery to the point of returning to or gaining employment. Other questions were developed in the field by the researcher as I gained more knowledge about the topic of study.

One question emerged related to the research question concerning medication compliance and was asked of each participant in a non-standardized question posed to them. The wording of this question varied with each individual. However, the question sought to determine how the individual decided to take medications regularly or not to take them regularly. Male 1 answered the question by stating that he had tried five or six different antipsychotics before settling on Clozaril. He found Clozaril to be most effective for him. Male 2 related he had been taking medications regularly since the age of 14 (he was then 37 years of age). Male 3 related that prior to his commitment to recovery in 1995, he would drink alcohol and consume other drugs rather than, or in addition to, taking antipsychotic medications. However, he had been compliant with medication for his mental illness for the past 12 years. All other participants indicated an ongoing compliance with antipsychotic medication. A common theme was an ongoing active compliance with medication regimens.

A second question emerged in the course of interviewing the participants. This question was also worded somewhat differently with each individual. It sought to determine each participant's thoughts and/or feelings regarding relapse since becoming employed. Male 1 had no real thoughts or feelings related to a potential relapse that he related to the researcher. Male 2 responded to the question of what would occur with his employment if he had to take time off for his illness with this statement: "Everybody says that if I have to take time off for my mental illness, that they might fire me."

Male 3 responded to this area of questioning by inferring that he felt his employer would understand should a relapse of his illness occur. Male 4 feared a relapse in regard

to how it would be received by his readership and the community in which he was a well-known newspaper reporter. Male 5 stated that he engaged in a technique he termed “reality checking” to determine if what he was seeing and hearing were things others saw and heard. He did this by asking others if they saw or heard what he thought he saw. He also gained reality checks in his relationship with his wife.

Male 6 had these thoughts about relapse and staying mentally healthy, although not necessarily in an employment setting:

I would agree that it's a continuous struggle every day. You have to watch, making sure that your thoughts aren't getting off, that you're becoming grandiose or paranoid. You have to make sure that the things you're hearing are really real, that you're not hallucinating. That's an everyday struggle, and I think that's an important part.

Female 1 expressed her thoughts about a possible relapse by stating that she had a strong support group which helped her deal with her illness through the local community mental health center. Female 2 thought that her employer would understand in the event she had a relapse and would hold her position for her. Female 2 worked in a group home for individuals with mental illness, and had just begun full-time employment there two weeks prior to the first interview. No clear statements were made regarding the question of the participants' thoughts and feelings which indicated fear for their jobs, other than Male 1's inference that if he became ill he might be fired. Two participants expressed a feeling that their respective employers would understand and be supportive. The other five participants chose to either not respond or respond in a manner that described symptoms of schizophrenia and how they dealt with these or how others were educated to deal with such symptoms.

The next question developed in the field was also worded differently with each individual. It sought to determine if the individual had a period of time in his or her recovery which he or she now recognized as a period in which he or she was not optimistic about future employment. Male 1 responded by relating a situation in which he was having auditory hallucinations. He stated, "One time, early on, I was trying to back the family car out of the driveway and I hit the house next door. That caused me to realize that there were some jobs I just couldn't do safely."

Male 2 related a period of time that he was a babysitter for his sister. He stated, "I was like a babysitter for my sister for a long time and them kids wouldn't listen to me. I thought that maybe that was all there was for me, and that made me feel very negative. Then I found a Christian woman and got married. We had a baby and that little check I was getting (SSI) was not enough. So I got out and found a good job. I feel a lot better about me now."

Males 4, 5, and 6 each related periods in which they initially questioned if employment was a realistic part of their future. For example, Male 5 stated, "I was not sure what I was capable of doing initially. Employment wasn't an option until I entered the Job Training Partnership Act program." Male 4 related, "At first I thought I might just wander around the country and be kind of a prophet, but I finally decided I needed to do some kind of work." Male 6 said, "I always wanted to work but wasn't sure of what I was able to do. After volunteering at the Red Cross for six months, I gained more stability and confidence." Neither Female 1 nor Female 2 was ever pessimistic about her employment abilities. Female 1 stated, "I always knew there was some kind of job out

there for me; if I could just find it.” Female 2 said, “I never thought I could not work at something.” Five of the participants at one point questioned their abilities to gain and sustain employment following diagnosis.

The next question developed in the field sought a discussion of each participant’s recovery process in as much detail as he or she chose to disclose. Male 1 responded to this type of question by relating a history of visual hallucinations beginning at the age of 12, and auditory hallucinations beginning around the age of 18, with both types of hallucinations continuing to the present. Male 2 stated, “My family kind of overprotected me when I first got sick, until a psychiatrist told them to stop, that I was not getting any better and that I loved being overprotected.” Male 3 told of a history of substance abuse that occurred during his hallucinations and delusions. He further related stopping all substance abuse in 1995 and committing to recovery from both substance abuse and his mental illness.

Male 4 stated his illness began while he was attending college in 1995. He had auditory and visual hallucinations, was hospitalized, and attempted suicide by overdose. During his senior year of college, he had a second psychotic episode which required a second hospitalization. Male 5 responded to this question by referring to his recovery as related to employment. He described a government/private enterprise program that was known as the Job Training Partnership Act (JTPA); it provided training for him in the field of computer programming. He stated the first five to six years were ones of economic hardship in his employment due to lack of medical insurance benefits.

Male 6 responded to this question by relating that the precipitator to his first psychotic break occurred while he was a captain in the army in charge of artillery in Germany. He stated that the purchase of new weapons by the army became so political for him to deal with that it caused him stress to the point of a psychotic break. He related that he felt this same type of political stress in the office environments where he was employed as a computer programmer; it became so severe that it caused him to stop working and receive full disability from the Veterans Administration. He had worked in private industry for approximately 17 years after gaining a college degree in computer science post-discharge from the army for a mental illness type of disability. He further stated that he had auditory hallucinations on the day of our last interview.

Female 1 related that her illness began at the age of 15 while she was in high school. She and her parents believed that she was suffering from depression at that time. However, a nurse at the hospital to which she was admitted suggested to her parents that she may be exhibiting symptoms of schizophrenia. She was diagnosed with schizophrenia before being released from the hospital. She has auditory hallucinations which were partially controlled at the time of the last interview. She also related a history of visual hallucinations which lessened over the years since her diagnosis 12 years ago.

Female 2 related that she had a history of visual hallucinations for as long as she could remember. She stated her first real psychotic break occurred at the age of 20 while she was living in Los Angeles. She was extremely paranoid and saw ghosts everywhere. She was diagnosed with schizoaffective disorder around her 22nd birthday, when she was

hospitalized for bulimia. She further related she sometimes had auditory hallucinations and some olfactory hallucinations.

All participants' accounts of their recovery involved a period of time when auditory hallucinations were present. With five of the participants, visual hallucinations were also present at some point prior to the last interview. Some of the participants continued to experience auditory hallucinations, while a few also experienced visual hallucinations at times. All were hospitalized for their mental illness at some point.

The next question developed in the field was whether or not the participant had or would be going to disclose his or her mental illness to the employer. Male 1 responded that he was open with his present employer concerning his mental illness. Male 2 has not formally disclosed his illness to his present employer, but he assumed his employer was aware of it due to the mandatory drug test he took prior to being hired. He assumed his medication showed up on the drug test and, therefore, his employer was aware of his illness. This seemed unrealistic because the employer would have had to test for antipsychotics. Male 3 was hired at an agency where he was formerly a client. The agency where he was employed knew of his dual diagnosis and, therefore, he had no need or desire to disclose his mental illness.

Female 2 related that she had been open with her former employer and her present employer about her mental illness and perceived no ill treatment due to this disclosure. In fact, as she explained, it helped her to better schedule doctors' appointments which were a necessity. Six of the participants disclosed their mental illness to their present employers either prior to or after hire.

The question regarding disclosure led to the next question regarding perceived stigma due to each participant's mental illness. Female 1 related that social stigma was problematic for her. She did not have many friends in high school and still didn't due to the stigma associated with her mental illness. However, she did not believe there was any stigma in regard to her employment. Female 2 said she never felt stigma in either of her employment positions. However, she related a perception of stigma due to her mental illness in college from her professors who, she stated, were inflexible regarding her attendance when she was experiencing symptoms of her mental illness. A sub-theme is stigma for five of the participants in this study. Where three experienced stigma in employment arenas, two experienced stigma socially and as students.

A question developed in the field was, "Do you feel like employment has affected the symptoms of your mental illness?" Male 1 stated that if he felt too stressed at work and symptoms of his mental illness began, he was able to sit in a comfortable chair until the symptoms decreased. Male 2 spoke of symptoms of his mental illness which he felt at work: "Sometimes I get irritable, but everybody gets irritable." Male 3 said that his perception was that his symptoms had decreased since he was focusing on other individuals' concerns rather than his own.

Male 4 had the following to say regarding symptoms of his mental illness and employment: "Not really related to employment, cause it's never really gotten that chaotic. I've always been able to keep it in check enough, you know, to a certain extent anyway. There's this time I went and talked to this high school class and brought up a lot

of old emotions, and when I came back to the job it was affecting me then. I was feeling off. Luckily, I've been able to keep my employment pretty stabilized."

Male 5 stated that there had been two occasions when symptoms of his illness had the potential of interfering with his employment. One was due to the death of his grandfather, which precipitated auditory hallucinations; and the other was during a strike at the corporation where he was employed at the time. The stress of the strike precipitated visual hallucinations. Both of these occasions required a change in medication that eventually resolved the symptoms. Seven of the eight participants in this study had some type of symptom which they perceived as being related to their mental illness and which occurred in the workplace.

The next question developed in the field sought the subjective evaluation of the participant regarding the benefits of employment. Male 1 answered by talking about the intrinsic reward he felt by helping other individuals with mental illness in the group work he did at a state hospital. Male 2 gave this answer: "Since I've been working, I feel better about myself. I feel that life's more meaningful. There is more to life than just laying around not doing nothing. Having a family and supporting them; that makes a person feel good. When you're working, you're getting your family's needs and wants. When you're on disability, you can't just do that." Four of the participants' responses suggested a theme of intrinsic rewards from employment, while four participants' responses suggested extrinsic rewards.

The next question was usually worded as follows: "Does your employer make any accommodations for you due to your mental illness?" Male 1 responded by stating that

his main employer was a consumer-run drop-in center and the manager allowed him to take the time he needed to sit down and relax until the auditory hallucinations ceased.

Male 2 said that his employer gave no accommodations and he asked for none. Male 3 responded by saying that he never asked for any accommodations; however, he assumed that his employer would be accommodating because he was employed in the mental health field. Males 4 and 5 also responded by stating that they did not ask their respective employers for any type of accommodations.

Male 6 never disclosed his mental illness to any of his employers, and no accommodations were asked for or received. Female 1's employer allowed her to wear headphones and listen to music when she was not dealing with a customer. Female 2 had not asked for any accommodations at her new full-time position. Six participants had not asked for nor did they receive any type of formal accommodations in the workplace.

The last question posed to the participants asked them to share their particular thoughts and ideas regarding what could be necessary for an individual with either schizophrenia or schizoaffective disorder to recover to the point of returning to or initially gaining employment. The question was generally worded in the following manner: "If you could advise someone who had a mental illness such as schizophrenia or schizoaffective disorder as to three things that are necessary to recover to the point of returning to or initially gaining employment, what would be those three things?" Male 1 answered as follows: "Number one, probably without a doubt, medication; understanding the illness, and a support system." Male 2 gave this advice: "...Go forward, but don't be

afraid to draw back if you have to...” Male 4 listed consistent medication as being vital to recovery to the point of employment. Male 5 stated, “I would say test your limits, be aware of the stressors, the things that may make your condition worse – drugs, alcohol, or hangin’ out with the wrong people.” Male 6 offered, “...Start small and build on it.” Female 1 stated, “There are a lot of different jobs out there.” Female 2 related, “I can take my medications and function and for a lot of people that doesn’t work, you know; and I didn’t know that until I had this job.”

The theme that was present in four of the participants’ advice to someone with either schizophrenia or schizoaffective disorder contemplating returning to or initially gaining employment was self-care. This theme included consistent medication, support systems, and approaching work gradually and carefully. Three mentioned beginning by volunteering and taking gradual steps toward either full or part-time work. All participants expressed encouragement.

Summary

This chapter included descriptive data listed in Tables 1 and 2. The themes and subthemes that emerged through content analysis are listed in Table 3. Results of this study, including some answers to the twelve formal research questions, have been reported. Categories that emerged were listed. They include (a) self-help, (b) employment, (c) assistance with employment, (d) benefits, (e) functioning at a perceived normal level while living as full a life as possible with the illness, and (f) recovery to employment. Themes that were present in the data were also listed, including (a) self-care, (b) employment issues, (c) supports, (d) benefits of employment, and (e) recovery

process. Subthemes under self-care were medication compliance and stress reduction. Subthemes under employment issues included (a) approaching employment gradually and carefully, (b) stigma, (c) disclosure of condition, (d) formal accommodations, (e) change of employers due to problems of disability, and (f) lack of failure. Subthemes under supports theme included: (a) family and friends, (b) government supports, and (c) private supports. Rewards of employment included the subthemes of intrinsic and extrinsic rewards, while the main theme of the recovery process included the subthemes of developmental process and normalcy.

Chapter Five, which follows, includes a discussion of the researcher's interpretation of the findings; conclusions drawn from these interpretations; and implications and recommendations for practice/application of findings. The chapter concludes with the researcher's ideas regarding further research in this area.

CHAPTER 5: DISCUSSION

This chapter includes an interpretation of the data and the conclusions that were drawn. These interpretations were accomplished through the van Kaam (1966) method of qualitative analysis, which has been described in Chapter 3. Implications for practice for mental health professionals who provided services for individuals with schizophrenia or schizoaffective disorder were offered. This chapter concludes with a summary and statement concerning future research with individuals who have either schizophrenia or schizoaffective disorder and the employment of them. Included in that statement are ideas concerning new research questions and a reflection section.

The major findings of this study are that recovery was perceived by the majority of participants to mean living as normal life as possible relative to the mainstream of American working society. The perception of recovery was a developmental process to the participants. The supports the participants had were mainly family, which lends credence to the Andresen et al. (2003) stage of recovery model preparation stage by seeking the assistance of others in one's recovery.

Six participants received government services for employment at some point in their recovery process. All participants were currently medication compliant. This compliance precipitated a reduction of negative symptoms in the participants. No clear theme was evident in the identification of available services for employment by the participants. Sub-themes of private assistance and government assistance experiences by the participants in returning to employment were revealed. These sub-themes lend

credence to both the Andresen et al. preparation stage and the Spaniol (2003) model of recovery.

Families were the major influence for employment decisions for most of the participants. A sub-theme of change to different employers due to past problems with employers was also revealed. A sub-theme of lack of failure with his or her current employer with all participants was present, as was a sub-theme of stress reduction.

All participants recognized the need for medication compliance to remain stable. This medication compliance supports the Thompson et al. (2003) finding of an integrative recovery style, in that of all participants in this study chose to not deny the need for medication with his or her mental illness. No clear theme was revealed in response to the question of relapse of his or her illness while employed. The majority of participants questioned their ability to return to or initially gain employment, generally around the time of the first release from the hospital. This finding may be related to the Andresen et al. (2003) stage of recovery termed *rebuilding*.

Auditory hallucinations were experienced by all participants at some point in their recovery and for some they have remained at a low level. Self-disclosure of his or her mental illness was practiced by the majority of participants. Stigma due to mental illness was experienced at some participants' employment, and in two participants' social lives. The majority of participants continued to experience positive symptoms of their mental illness while employed and maintaining medication compliance. Half of the participants experienced intrinsic rewards from employment and half experienced extrinsic rewards. No accommodations from employers were asked for or received by the majority of

participants. Advice to someone who has schizophrenia or schizoaffective disorder and is contemplating employment revealed themes of medication compliance and securing and maintaining a support system.

The Recovery Process

The participants in this study seemed to want to be viewed as normal working people as concluded by the researcher. It can be further interpreted that the individuals in this study were dealing with recovery from a biological illness similar to heart disease, diabetes, lupus, epilepsy, cancer, or any other type of potentially disabling medical disorder. They were more alike than different from the majority of “normal” individuals. Their perception of normalcy seemed to help motivate the participants in this study to obtain and maintain employment.

The recovery process to the point of employment was ongoing and developmental. This conclusion is supported by the participants’ statements and in part by the Andresen et al. (2003) stage model of recovery. In that model, the researchers discovered that the final stage of recovery was growth. In this stage, the individual knows how to deal with his or her mental illness and continually looks forward to a future. The same can be said for the participants in this study. They continually looked forward to the future as positive and dealt with realities of their mental illness in a developmental manner, remaining open to all possibilities of improving their quality of life.

Family supports had the largest impact on individuals in the recovery to employment process. This conclusion is warranted from the sub-theme of family supports in seven participants’ recovery to employment process. This conclusion also supports the

research done by Andresen et al. (2003) in their stage model of recovery. The participants of this study could be concluded to have gone through the preparation stage of that model at some point in their recovery to employment process. The preparation stage involves learning about mental illness through connecting with peers and participating in groups, as many of the participants have done.

The next conclusion derived from the major theme of supports for employment at some point in the recovery to employment process is that many people with either schizophrenia or schizoaffective disorder could use formal services at some point in their respective process. This conclusion is warranted from six of the eight participants' experiences with formal supports in the recovery to employment process. These formal services were all government-funded.

Medication compliance to decrease positive symptoms of either schizophrenia or schizoaffective disorder was a sub-theme; the negative feelings participants had regarding the inability of medication to take away all symptoms leads this researcher to the conclusion that medication compliance is vital to the recovery to employment process. However, the negative feelings expressed by participants warrants the conclusion that medication alone is not as effective as many people with either disorder desire.

Formal and personal services are equally identified by people with either schizophrenia or schizoaffective disorder in the process of recovery to employment. This conclusion comes from the inability of the researcher to come to a significant interpretation of how such services were commonly identified by the participants. It seems that further research in this area is warranted.

The next conclusion is that both the Andresen et al. (2003) preparation stage and the Spaniol (2003) phase model of recovery explain how all participants received employment assistance either through private assistance or government assistance. The preparation stage conclusion arises from the participants seeking assistance through contact with peers or groups of consumers. This is reflective of the Andresen preparation stage as the participants are seeking assistance from others – a main precept of this stage. Spaniol's research indicated a living-with phase, which involves attempting to be as productive as possible even though the illness is present. Participants attempted to establish themselves in a productive role, which is a part of the living-with phase of that recovery model. It seems that both of these models could be applied to the recovery to employment process due to all participants experiencing both models of recovery at some point in that process. They all experienced the Andresen (2003) five-stage model, which is described as follows: *Moratorium* is a stage that is characterized by denial, confusion, hopelessness, a confused identity, and protective self-withdrawal; all participants related they went through these early after being diagnosed.

A second stage termed *awareness* involves the person having a first glimmer of hope of a better life and that recovery is possible. Each participant experienced this stage. This can be an internal event, or can be sparked by a clinician, a significant other, or a role model. It involves an awareness of a possible self other than that of a sick person; a self that is capable of recovery. All participants could be interpreted as going through this stage at different times after diagnosis. Next is the *preparation* stage, which began with a resolve to start working on recovery. This stage involves taking stock of the intact self,

and of one's values, strengths, and weaknesses. It involves learning about mental illness and services available, acquiring recovery skills, becoming involved in groups, and connecting with peers. All participants spoke of a time in which they did a self-reevaluation following diagnosis. This time period was different for each participant. However, it could be interpreted that they all experienced the preparation stage.

Rebuilding is the stage in which the hard work of recovery takes place and the person works to forge a positive identity. This involves setting and working towards personally valued goals and may involve reassessing old goals and values. This stage involves taking responsibility for managing the illness and taking control of one's life. It involves taking risks, suffering setbacks, and coming back to try again. All participants in this study took risks and suffered setbacks, but they persevered.

Growth is the final stage of recovery in the Andresen model. It is considered the outcome of the recovery process. The person may not be free of symptoms completely but knows how to manage the illness and to stay well. The person is resilient in the face of setbacks and has faith in his or her own ability to pull through and maintain a positive outlook. The person lives a full and meaningful life and looks forward to the future. He or she has a positive sense of self, feeling that the experience has made him or her a better person than he or she might otherwise have been. All participants in this study support the five-stage model of recovery. The growth stage is reflective of all participants' current recovery to employment reality. Although they may not be totally free of symptoms, they each have the resiliency to suffer setbacks and try again. They all have a positive outlook on their own futures and live a personally meaningful life.

There seems to be sufficient evidence obtained from the data to consider the Andresen stage model as non-linear as experienced by participants. It is more suggestive of an upward spiraling type of model with some interactions between the stages. For example, all participants went through the moratorium phase and the awareness stage; however, their progression was not entirely linear. Male 1 spoke of being aware he had a mental illness but denying the realities of living with that illness. He then progressed slowly to the next stage of preparation for living his life with his illness. He shifted back and forth for a significant amount of time. Preparation and rebuilding were encountered in this manner. He eventually arrived and remained at the end stage or level named growth. Similar experiences were encountered by all participants.

Self-motivation is an influence on some peoples' decision process of returning to employment. This conclusion may be warranted by the sub-theme of family supports revealed through data analysis in this study. Self-motivation was present in a few participants' decisions in the recovery to employment process.

The Kirsch (2000) findings were supported with the presence of positive relations with employers by the majority of participants. This conclusion seems warranted by the participants' apparent congruence of workplace climate with their values. This congruence was the major finding in the Kirsch study. A further conclusion in this study is that if positive relations with one's employer are not present, he or she changes employers. This conclusion is also warranted by the majority of participants' theme of positive relations with their employers. If that is impossible, a change to other employers, or a receipt of full disability benefits was also stated as a possibility by two participants.

An individual's perception of failure is vital to the recovery to employment process. This conclusion seems apparent by the high degree of persistence and evolution of perception of what constitutes failure by the participants in this study. The majority experienced a lack of failure as perceived by them. However, some experienced numerous setbacks in their process of recovery to employment, but they came back and were persistent in their efforts to gain and maintain appropriate employment.

All individuals in the study reached the growth stage of the Andresen et al. (2003) stage of recovery model. This conclusion seems warranted by each participant's use of cognitive or behavioral techniques to deal with the stress of his or her employment. Again, the growth stage of that model involved the ability to manage the symptoms of one's illnesses and had a positive sense of self which all related. Furthermore, they were optimistic regarding their futures.

Fear of relapse of one's illness after gaining employment was unique to each individual. This conclusion was reached by the researcher due to the lack of a clear theme through data and thematic analysis of the question which asked each participant's feelings regarding relapse while employed. While another researcher might have been able to discern a pattern in the data collected, this researcher did not.

The stage of recovery known as the rebuilding stage in the Andresen et al. (2003) stage model of recovery is relevant to each male's self-perception of his ability to return to and maintain employment. This conclusion was arrived at by analysis of the data which revealed that each of the six male participants questioned his ability to return to employment after release from his hospitalization. The rebuilding stage was then entered

into by each male participant, it would seem. This stage involves taking responsibility for managing one's illness and taking control of one's life. In addition, it involves taking risks, suffering setbacks, and coming back to try again. It can be further concluded that had each male not entered this stage of recovery, his recovery to the point of gaining and maintaining employment would not have occurred. Neither female expressed doubt of gaining employment throughout her recovery process. It can also be interpreted that both female participants also experienced the rebuilding stage due to each suffering setbacks, taking risks, and coming back to try again. The fact that neither female was ever doubtful of gaining employment is a relevant finding and can lead to the conclusion that the females may have more resiliency in employment possibilities than the males in this sample.

Stigma is a theme in the lives of many people with either schizophrenia or schizoaffective disorder; and it can be related to employment. This conclusion is based on the findings of three participants' perception of stigma in the workplace and two participants' experiences socially. However, all participants related an awareness of stigma associated with a mental illness such as schizophrenia or schizoaffective disorder.

Having no symptoms of schizophrenia or schizoaffective disorder is an unrealistic expectation of people with either disorder who are employed. Analysis revealed that positive symptoms are experienced by the majority of participants in this study. These positive symptoms continue for participants who were employed and were medication-compliant.

Formal workplace accommodations were not needed by six of the participants. This conclusion is based on the interpretation that formal accommodations seem unrelated to their recovery to employment process and was arrived at through the sub-theme that no accommodations were asked for or received by six participants in this study.

The process of recovery to employment involves a development of perspective on recovery from schizophrenia or schizoaffective disorder in general. This process has probable relation to the Andresen et al. (2003) stage model of recovery and the Spaniol (2003) phase model of recovery. It is further related to family support systems and family influences on employment perspectives. In addition, this process is enhanced in continuing once employment is gained by positive relations with one's employer. The individual's perceptions of failure and medication compliance are vital to the recovery to employment process. Also, the individual's use of cognitive behavioral techniques to deal with stress at work is important in maintaining this process. Self-disclosure of one's mental illness is related to an enhancement of the recovery to employment process. Formal accommodations in the workplace were not related to the recovery to employment process in this study.

Interpretation of Categories

Analysis of the data revealed some common categories such as functioning at a perceived normal level and living as full a life as possible with their illness. Male 3, Male 4, and Female 2 mentioned being able to function at a perceived normal level. From the discussions of recovery with these participants, I was able to recognize functioning at a

perceived normal level and living as full a life as possible with the illness as two commonalities regarding recovery. I developed these two categories from the general language that these three participants used in reference to the word *recovery* and research question number one. Further review of these three participant's answers to other questions and general language used in open discussions suggest that their perception of a normal level was in comparison to the mainstream of society. For example, Male 3 spoke of the possessions he was able to have due to employment which employed people had throughout their working lives.

Seven participants spoke of their perceptions of recovery in a similar manner. However, they related recovery to be an ongoing process of dealing with their illness or getting over their illness and living as full a life as possible. Analysis of the data of all questions and all comments of the participants revealed this developmental process of recovery as being instrumental to all participants in their recovery process to the point of gaining and maintaining employment. This developmental process was a pattern in five qualitative studies conducted on recovery from mental illnesses (Baxter and Diehl, 1998; Davidson and Strauss, 1992; Pettie and Triolo, 1999; Spaniol, et al. 2002; Young and Ensign, 1999). The developmental process of recovery was included in the general category of recovery to the point of employment. Living as much as possible in a perceived normal manner was included in another category. Two sub- themes were arrived at through repeated reading and the van Kamm (1966) method of testing the transcripts for invariant constituents. One sub-theme was the developmental process of

recovery and the other was normalcy. These two sub-themes were grouped under the main theme of recovery process.

Perceptions of Recovery

Seven perceptions of recovery by participants could be interpreted as being similar to the Andersen, et al. (1994) qualitative study of recovery. That study found the loss of a sense of identity with schizophrenia and the process of self-redefinition as being central to recovery. This is expressed in the following quotation from a participant in the Andresen et al. study: “My illness eradicated my sense of self, and now I am engaged in the lifelong process of obtaining, maintaining, and slowly modifying my sense of who I am” (p. 590). The data from the current study revealed a similar conceptual change in self as indicated by seven of the participants.

Male 5 stated his change of concept succinctly in the following response to research question two: “Initially it was survival, overcoming trauma, reconciling my situation. It moved from there through a series of steps, to what is now a pretty meaningful life, as much as any life is normal.” This developmental process of recovery to the point of becoming and remaining employed was further confirmed by Male 3’s response to the same research question: “I’m still learning all the time, and my idea of who I am and how I fit into the world is still evolving.”

Sub-theme of Normalcy. A sub-theme in the recovery to employment process is the striving for a perceived degree of normalcy, as was reflected in Female 2’s response to research question number two: “I’ve always strived to just have a normal life.” Female

I also states, “I can function most of the time fairly normally. I don’t have to be locked up.”

Assistance from Others

The category of assistance from others became clear after reading the transcripts repeatedly and recognizing that each individual was assisted in some way by others in his or her recovery to employment. Thematic analysis of the data by the van Kaam (1966) method revealed that seven of the eight participants mentioned family support as important to their return to employment. This was interpreted by me as being included as a sub-theme under the main theme of supports in the recovery to employment process. The seven individuals explained how their families had assisted them in recovery to the point of employment. Females 1 and 2 and Male 1 were all heavily influenced by their parents in returning to employment. All three basically stated that their parents would not accept that they were not working and receiving disability benefits. This was an unexpected finding in relation to the recovery to employment literature reviewed for this study. No studies were found that investigated family support systems as being connected to employment of individuals with either schizophrenia or schizoaffective disorder.

Supports Theme. This general theme of supports along with the sub-theme of family support was interpreted as relating to the Andresen et al. (2003) stage of recovery model termed the *preparation* stage. In this stage, the individual is influenced by others in his or her recovery process. This influence was further revealed through content analysis of the data which showed that seven of the eight participants were influenced by their families in the decision to obtain or return to employment following diagnosis.

Other sub-themes which were grouped under the category of assistance from others and the theme of supports were governmental and private supports. Both of these types of support were encountered by seven of the eight participants in this study. The majority of participants received some type of governmental support at some point in their recovery to employment process.

Supported Employment Comparison. In the late 1980s, supported employment was implemented on the state level through a combination of state mental health authorities with state vocational rehabilitation services (Knisley, Hyde, and Jackson, 2003). This initiative spurred the individual placement and support (IPS) model of vocational services (Becker, Bond, and McCarthy, 2001; Becker and Drake, 1994). This model provides necessary supports and job coaching (Bond, Drake, and Mueser, 1997; Drake et al., 2000). This type of support was provided for Male 2 in his initial efforts to find and maintain employment. However, he did not use this type of service to gain or maintain his current employment; he used private supports to gain his current position. From this single case, no valid conclusion can be drawn as to the effectiveness of IPS services.

Job Search Strategies. The remaining participants used known sources of job-search strategies used by most individuals without disabilities in seeking employment. They were successful in their attempts using their own personal support systems. For example, Male 3 used his contacts with the local mental health community in securing part-time employment in the mental health field. Male 1 did the same also, with parental assistance. Male 4 used strategies unique to the journalism field to secure his full-time

employment. Female 2 used her ingenuity and the Internet in locating what eventually became full-time employment.

This led the researcher to determine that personal contacts and conventional job search strategies were as effective as formal services in the participants' return to employment. However, it must also be noted that there were varying degrees of severity of symptoms at different times among the participants in their recovery. Also the majority of participants had formal services for employment at some point in their recovery. It seems likely that formal services are used by many people with schizophrenia or schizoaffective disorder in their attempts to return to or gain initial employment. What is not clear from this study is the effectiveness of such services.

Male 6, for example, was given a medical discharge from the army within six months of his first episode; but he was able to regain stability within six months after leaving the army and returned to college full-time. He worked for 17 years as a computer programmer for different firms until he could no longer tolerate the stress of perceived office politics in 2004. This stress caused a decompensation to the point that he received full disability from the Veterans Administration. Male 6 found rehabilitation services through his experience in the army. These services had a positive impact upon Male 6's recovery to employment process; therefore, the services provided could be considered as effective in Male 6's case.

Another example of the effectiveness of services is Male 5's experience in a day treatment program in a Midwestern state when he was told about the Job Training Partnership Act (JTPA) by employees of the day treatment program. It is my

interpretation that this program significantly improved this man's quality of life. He stated in his own words he probably would not have survived without the day treatment program and the assistance he received through the JTPA. The program provided needed structure for him and also helped him withstand full-time employment following the onset of his illness and his diagnosis.

Awareness Stage of Recovery. It is my interpretation that the second stage of the Andresen et al. (2003) five stages of recovery model termed *awareness* was encountered by all participants at some point in the recovery to employment process. In this stage, the person has a first glimmer of hope of a better life and that recovery is possible. This can be an internal event or can be sparked by a clinician, a significant other, or a role model. It involves an awareness of a possible self other than that of a sick person; a self that is capable of recovery. Half of the participants' experiences address the Jacobsen's (2001) external condition of policies, which consider government and private policies as being a factor in recovery to employment. Four of the eight participants were assisted by public agencies in their return to or initial gaining of employment.

Evidence to support the awareness stage conclusion can be found throughout the statements of all eight participants. For example, Male 1 spoke of how his family assisted and continued to assist him in gaining and maintaining employment. This relates to the awareness stage in that Male 1's significant others (family) sparked and continued to assist in his self-concept of not being a sick person but a person capable of gaining and maintaining employment in his recovery.

Male 3's initial recovery was sparked by his significant others, specifically his family of origin. Male 4 also related the same support system of family that sparked his initial recovery and led to his returning to employment on a full-time basis.

Male 5 recognized his family as being very important in his recovery, but also his contact with public agencies led to his recovery to the point of full-time employment. It seems that the majority of participants were aided by their families in the recovery to employment process. This reflects a support system that is very beneficial to participants.

Category of Self-Help

As I read through the data and looked for invariant constituents, located them, and tested them as being necessary and sufficient to the general understanding of the stated purpose for my research, I developed the "self-help" category, which includes the sub-theme of medication compliance. All eight participants stated that they took medications regularly for their mental illness. Female 2 admitted that at some points in the past she has stopped taking medication in an effort to enhance her creativity, but later she felt that such a practice is wrong and she would not repeat it in the future. Female 1, Male 2, and Male 6 reported still having positive symptoms even with consistent medication compliance. Lehman and Steinwachs (1998) concluded that medication compliance reduces positive symptoms in 50% to 85% of individuals with either schizophrenia or schizoaffective disorder. The individuals in the present study did say that their positive symptoms were reduced since starting on their respective medications. This is reflective of the Lehman and Steinwachs (1998) statistics.

Theme of Self-Care. Analysis of the data revealed a further theme of self-care in relation to the area of discussion of medication compliance. This theme of self-care included dialogue which suggested a reduction in positive symptoms from medication compliance. Other statements suggested a negative feeling by participants that symptoms were not entirely controlled by medication. This is likely a relevant finding, since all participants were medication compliant and able to work. It could have significance for rehabilitation counselors and other mental health professionals in encouraging individuals with either schizophrenia or schizoaffective disorder who wish to be employed to be medication compliant. Medication compliance is important to the recovery process to the point of gaining and maintaining employment for the participants of this study, and it can be interpreted as an important aspect of self-care by the participants.

Assistance with Employment

The category of assistance with employment became apparent after repeated readings of the transcripts and was related to the theme of supports. Sub-themes under supports included governmental and private supports. Evidence from this study seems to support the fact that personal friends' knowledge of services helped two participants identify available services, while structured agencies and personal knowledge through former employment helped two others in the identification process. The other participants were assisted by family or through their own ingenuity. Therefore, it can be said that assistance with employment in this population can come from both private and formal services. These same methods are also used by the general public in seeking and gaining employment.

Supports Theme

Under the category of assistance from others, the participants' statements throughout the interviews suggested that they had gone through the Andresen et al. (2003) preparation stage, which involves learning about mental illness, connecting with peers, and finding supports. The type of support came mostly from families and friends of the majority of the participants. This demonstrates to this researcher the effectiveness of family and friends in the Andresen et al. (2003) preparation stage, and a possible inclusion of both in this stage of recovery model.

For example, Male 1 stated, "My family always told me I could do something besides watch TV all day." Male 2 stated, "My parents were not going to allow me to do nothing." Female 1 also had similar experiences with her parents as she stated, "My parents told me I had to keep trying to find something that I liked and they encouraged me." Female 2 said, "No way were my parents going to allow me to just get disability." These four also spoke of how peers in the mental health system assisted them in learning more about their mental illness and how to deal with their limitations. These findings lend credence to both the preparation stage of Andersen et al. (2003) and two of the phases of the Spaniol (2003) model: struggling with and living with the disorder. In addition, Males 4 and 5 were initially assisted in their recovery by their parents through financial and emotional support. However, they differed in how they were assisted in returning to employment. Male 4 used resources he had gained through his education in journalism to secure employment as a reporter for a newspaper, whereas Male 5 was assisted and received training in computer programming through a government private

enterprise joint venture known as the JTPA. They could be considered to have been in the preparation stage of the Andersen et al. (2003) stage model at the point prior to gaining employment in that both these males spoke of educating themselves through others about their respective illnesses – another aspect of the Andersen et al. (2003) preparation stage. In fact, all participants in the study considered themselves to still be learning about their respective illnesses and how they could best live as high a quality of life as possible and remain stable.

This last observation is especially true of Male 6. He related that the one individual who impacted his recovery to the point that he was able to understand his illness was the author E. Fuller Torrey, M.D., who wrote the book titled *Surviving Schizophrenia*. Male 6 gave credit to this book and also his volunteer work at the Red Cross as being instrumental to his ability to return to college, which led to 17 years of employment as a computer programmer.

Male 3 related that his family, peer, and professional contacts in the town in which he resided played a major role in supporting his recovery and helping him understand his dual diagnosis of schizophrenia and substance dependence. He gave credit to the local mental health board director in the area where he lived as giving him the opportunity to gradually try to return to part-time employment in the addictions recovery field. His experience could also be related to the Andersen et al. (2003) preparation stage of recovery prior to his gaining employment due to learning more about his illness through contacts with peers and professionals. It could also be related to the two phases of the Spaniol (2003) model known as struggling with and living with the illness. Both of

these models of recovery seem relevant to the recovery process that all participants appear to have experienced. The recovery process and its relation to these recovery models became evident through thematic analysis of the data collected.

Employment Category

A category termed *employment* was developed by the researcher. Stress reduction was a sub-theme in this study under the main theme of self-care, both under the category of employment. Also under the category of employment was the theme of *disclosure of illness*. Disclosure was practiced by six participants in their employment environments. For those who did not choose to disclose their illness to their employer, none suffered any adverse affects in his or her job. Participants in this study who disclosed suggest a commonality regarding disclosure to employers in general.

Values. It is likely that the findings of the Kirsch (2000) study support the interpretation that a congruence of workplace climate with these participant's values are occurring. The Kirsch (2000) study found that when an individual with schizophrenia has a similar value system as the overall climate of the workplace in which he or she is employed, tenure is enhanced. The experiences of the majority of participants in this study seem to coincide with the findings of that study. Six participants stated that they were happy with their employment and that they felt it was meaningful work. They further stated that they intended to stay with their present employer.

Workplace Stress. The category of employment includes how the participants dealt with on-the-job stress. All participants dealt with such stress through a combination of cognitive and behavioral techniques. For example, Female 2 used the behavioral

technique of playing the French horn and by changing her initial thought patterns from negative to positive through engaging in positive self-talk. Male 1 used the behavioral technique of sitting down in a comfortable chair while using the cognitive technique of self-soothing thoughts. All other participants used similar types of cognitive behavioral techniques for stress reduction, which is important for individuals with these disorders as excessive stress is known to be a trigger for relapse as stated by the participants.

Male 3 stated the only stress he had in his employment was becoming adjusted to a regular work schedule and learning the coding for billing for his services at his employment. This type of response could be interpreted as a problem-solving skill for this participant due to his ability to adjust to the work environment by learning the codes and the work schedule and applying this learning to a new situation (problem). This is a type of skill which was most likely used to a limited degree prior to stable employment. Male 5 related that he was laid off for six months at his old place of employment. He then proceeded to talk about the lack of benefits he experienced for the first four to six years after returning to employment. This experience with lack of benefits with employment was a finding in the Secker et al. (2001) study who found that 70% of the individuals with schizophrenia who were studied cited worries over benefits as being their main reason for not seeking employment. Male 5's first years of recovery through employment could provide empirical evidence in support of the Secker et al. study. Male 5 could further be interpreted as going through his rebuilding stage using the Andersen et al. (2003) stage model of recovery, in that he was taking control of his life even in the face of lack of benefits from his employer at that developmental point in his recovery.

Male 6 stated that he never told any of his employers over the 17 year period he was employed that he had a mental illness of any type. He further stated that he did not ask for any accommodations other than to take time off with short notice due to stress. Male 6's experience could be interpreted as being related to the rebuilding stage of recovery while he was employed, because he was taking control of managing his illness through time off due to stress and coming back to try again. Also under the category of employment, Male 6 and the majority of the participants related that they had not asked for or received any formal accommodations in their present employment.

Female 1's employment experience could be interpreted as also being a part of the rebuilding stage of recovery due to her several trial work periods through the Bureau of the Visually Impaired. Each of these trial work periods was unsuccessful. Female 1 continued to take risks, suffer setbacks, and always went back to try again. As for her current employment, she dealt with stress and symptoms of her illness by using her cell phone to call her mother for emotional support or the potential of having to leave work, although the need to leave work never arose at her current employment. Female 2 stated she had no problems at her current or previous employment.

All participants could be considered to have gone through the rebuilding stage of the Andresen et al. (2003) stage model of recovery for the reasons cited. Thematic analysis by the van Kaam method (1966) revealed a theme of employment issues with a sub-theme of change to different employers if any problems arose. One participant chose full disability benefits in response to problems with his employer. This sub-theme could reflect a possible coping mechanism for other individuals with either disorder. It is

possible that others choose full disability as a coping mechanism for problems with employers also.

Lack of Failure. A sub-theme that arose from content analysis of the responses to research questions and the general discussion of all interviews was a relative lack of failure among participants in the employment arena. This sub-theme seems to have many different possible interpretations. It could be that the participants in the study had a high degree of persistence or perseverance in the workplace. It could also be that their perception of failure differed from the majority of individuals' perception of failure. In addition, it could be that each had his or her own unique interpretation of the word *failure* in relation to employment. It is further possible that they gained a different perception of failure through their recovery process to the point of gaining and maintaining employment; a development of perception, so to speak. The majority related no failures in the employment arena. This leads this researcher to conclude that perception of failure is possibly vital to the process of recovery to the point of gaining and maintaining employment in this study. This is useful information that could affect treatment by a mental health professional, if the professional can facilitate this type of view in clients who are attempting to return to employment.

Growth Stage. It is this researcher's conclusion that all eight participants reached the growth stage. It seems that each of the eight knew how to manage the symptoms of his or her illness. They each had resilience in the face of setbacks and a positive sense of self. They all looked forward to the future as being better for them.

These conclusions were arrived at through the personal interviews and data analysis. All participants used cognitive and/or behavioral techniques to manage stress in the workplace. It seems that these types of coping skills were effective for the participants. It is unclear if they learned these through contact with mental health professionals, with other consumers, through self-education, or through trial and error.

Interpretations of Additional Field Questions

One question related to how the participant felt about taking medications for his or her illness and if he or she went through periods of not taking medication. If the individual with either disorder does not have the symptom known as *anosognosia* (the inability to discern that they have an illness) (Amador and Paul-Oduard, 2000), then medication compliance could be an eventual reality that the individual recognizes as necessary for some semblance of stability.

Male 1 answered that he had been taking Clozaril since 1993, after trying five or six other antipsychotics. He related that the side effects of the other medications were intolerable. Male 2 stated that he had been taking medication for his mental illness since the age of 14, when he was first hospitalized. He related that he knew he would have to take them the rest of his life because that's what he was told while in the hospital. He stated that when he was told this, it did not make him feel any particular emotions.

Male 3 related periods of stopping and starting medications in the past. He also stated that he used alcohol and drugs during times when he was and was not taking medication. Male 4 expressed that the main motivator for him to be medication-compliant was the severity of the first episode of his illness which he experienced. Male 5

related that he took medication regularly for 20 years and did not think he could function without it. Male 6 related a similar experience with trying six different antipsychotics before he found the one which worked best for him, and he also took medication regularly for 20 years.

Female 1 stated that she was still looking for a medication or combination of medications which would stop the auditory hallucinations she experienced with her mental illness. Female 2 stated that, like Male 3, she sometimes stopped taking medication. It seems relevant that seven of the eight participants had difficulties finding a medication which worked best for them, mostly through what appears to be a trial and error process.

Stability through Medication Compliance. Medication compliance is a sub-theme under the main theme of self-care. All participants recognized the need to take medication on a consistent basis to achieve the level of stability which they experienced. This level of stability enabled them all to maintain employment – some full-time, others part-time. These findings lend further credence to Lehman and Steinwachs (1998) findings, due to the lessening of positive symptoms through medication compliance.

It could also be interpreted that all participants integrated their illness experiences into their wider life situation (Thompson, McGorry, and Harrigan, 2003), rather than seal over or deny their illnesses. Thompson et al. found these aspects to be correlated with recovery styles and levels of functioning at 12 months following stabilization of the first episode of psychosis. Those who integrated their illness experiences were determined to be functioning at a higher level than those individuals who chose to deny their illness.

The data from this study supports the integration of participants' illnesses into their wider life situation due to acceptance of their illness as only a part of themselves as individuals. Although Male 3 initially chose to deny his illness through drug and alcohol use, it could be interpreted that he had not truly accepted his illness until 1995, when he stopped using drugs and alcohol. Therefore, it could further be interpreted that he did reach the integrative style of recovery but not within the 12-month period suggested by Thompson et al. This could be due to the fact that his illness was not stabilized until 1995.

Furthermore, it seems that the integrative and seal-over styles of recovery could be related to many individuals who eventually recover to the point of returning to or initially securing employment, due to the reasoning that such individuals would need to accept their illness in order to maintain the stability required to become and stay employed. A major aspect of maintaining stability was found to be medication compliance in this study. Participants' medication compliance could be interpreted as being a prime factor in their ability to recover to the point of gaining and maintaining employment.

Possible Relapse

In regard to participants' feelings as to the possibility of relapse of their illness while employed, Male 2 expressed that he might be fired if he had to take time off due to his illness. This would seem to indicate a lack of knowledge of the Americans with Disabilities Act by Male 2. However, Male 2 may have been the type of individual who was not litigious in any way. Male 3 felt that his employer would be willing to help him keep his position in the event of a relapse. Male 4 seemed to fear the consequences of a potential relapse due to the public image he developed as a well-known newspaper

reporter locally. Male 5 responded by explaining his coping mechanism technique he termed “reality checking.” This technique involves asking others if some thought or action seems bizarre to them. He also asked his wife the same types of questions if he was unsure if his thoughts or actions were decompensating. Male 6 gave a similar response regarding the struggle he had gone through and continued to go through in separating thoughts which may be paranoid or grandiose from the normal thought process. This type of struggle to separate reality from unreality was an ongoing process to some employed participants in this study. It could lead to a constant fear of relapse for some individuals; however, it could also lead to a greater determination to try to control a potential relapse by recognizing its possibility. Recognizing symptoms of a potential relapse and taking appropriate action, such as consulting with their psychiatrist, seemed to be instrumental to participants’ ability to gain and maintain employment.

However, unlike Male 5, Male 6 did not relate a coping mechanism in which other peoples’ perception of his thoughts and actions were gauged. In his own words, “you’re never 100 percent sure what reality is. You have to adjust accordingly.” Male 6 did not have a well-established coping mechanism such as Male 5 had to receive feedback from others on how he was functioning. This feedback system may have been partially responsible for Male 5’s continuation of employment, whereas Male 6 had stopped paid employment.

Female 1 expressed her fear of relapse related to working during a higher stress holiday season. However, she further expressed coping techniques such as reading inspirational books which she learned about through church groups, and attending

support groups for her illness. These activities helped her deal with the fear of relapse and also the day-to-day stress of dealing with a major mental illness and being employed. Female 2 had no fear of relapse related to her employment and thought that her employer would hold her position in the event of a relapse of her mental illness.

It seems that only Male 5 and Female 1 had a well-established coping mechanism for dealing with the anxiety related to potential relapse of illness and its effect on their respective employment experiences. Male 3 and Female 2 had the feeling that their employers would hold their positions in the event either experienced a relapse. Male 2 seemed to fear that if he experienced a relapse, his current employment would cease forever.

A sensitive area in disabled employee/employer relations is what happens if the employee with a mental illness such as schizophrenia has a relapse. Would his or her position be held until he or she recovered and was able to return? It is an area which the Americans with Disabilities Act of 1990 sought to remedy (Olsheski and Schelat, 2003). However, it would seem to this researcher that, since no participant in this study even discussed a plan of action in the event of relapse with his or her employer, some degree of perceived ineffectiveness or ignorance of the act was present among these individuals. The ADA defines a qualified person with a disability as an individual who can perform the essential functions of the job held or desired with or without reasonable accommodations (Adams, 1991).

Modifying the work schedules of persons with disabilities and modification of company policies (Rubin and Roessler, 1995) are listed as reasonable accommodations

in the act. A reasonable accommodation would seem to be applicable in the event of a relapse of an employee's illness to this researcher. This type of accommodation by the employer could aid in the recovery to employment process of other individuals with either schizophrenia or schizoaffective disorder through a lessening of the fear of losing their employment due to relapse. This seemed to be a fear expressed by Male 2. It could be interpreted that a fear of relapse can be experienced by anyone with a medical condition. Some examples are individuals with diabetes, epilepsy, cancer, heart disease, and any other potentially disabling condition.

Periods of Pessimism. One question sought to determine if the individual had a period of time in his or her recovery in which he or she was not optimistic about future employment. Male 1 basically stated that he had an ongoing concern as to his ability to maintain or increase employment due to his symptoms of auditory hallucinations. Male 2 related that while he was drawing Social Security benefits, he helped his sister with her children and did housework at her home. He thought that his life would always consist of this type of activity, which caused him an increase in depression. He further related that the turning point for him in deciding to try to return to employment was when he became married. He was not satisfied with the income he was receiving from Social Security and felt the need and desire to better support his spouse and their daughter. Male 3 related that prior to his commitment to recovery in 1995, he was unsure of his ability to gain and maintain employment. He stated that his turning point came with his commitment to recovery.

All participants could be considered as going through the rebuilding stage of the Andresen et al. (2003) stage model of recovery at one point in their recovery to the point of employment. The majority of the participants questioned their respective abilities to gain and maintain employment at some point in their recovery. For most, it was following the period of release from hospitalization, which all participants experienced. Findings which related to questioning if employment would be a part of the future following diagnosis were grouped under the category of self-help and also under the category of recovery to employment. As for self-help, it can be interpreted that the participants' eventual decision to attempt employment was an effort to improve their quality of life and also achieve as high a degree of perceived normalcy as possible. These two aspects of self-help could also be considered a part of the recovery process in gaining and maintaining employment due to six of the participants having similar thoughts and feelings in regard to finding and maintaining employment with the possibility of relapse being present.

Individual Recovery Interpretations. The participants' individual recovery experiences, while being unique, each contained a degree of commonality. The age of onset with both female participants was similar as was their knowledge that they could and would find employment eventually. This lack of doubt about being able to gain and maintain employment was further present in all male participants when they reached the rebuilding stage of the Andresen et al. (2003) stage of recovery as interpreted by this researcher. Each participant's recovery experience could be interpreted as relating to the Thompson et al. (2003) study due to eventually being an integrative recovery style.

Auditory hallucinations were present in all participants at some point in their recovery. As these are common symptoms of schizophrenia or schizoaffective disorder, this finding was not surprising. Participants were able to work while still experiencing these symptoms.

McGurk et al. (2004) found no evidence to suggest that work problems increase cognitive symptoms or that work reduces cognitive symptoms. The overall interpretations of the present study would support the McGurk et al. findings. Participants varied in the amount of symptoms they experienced prior to and after becoming employed. Only one participant stated that employment caused any type of change in his symptoms. Male 3 stated that he felt his symptoms lessened since he was employed. The findings of each participant's recovery process from the time of first diagnosis relates to the category of self-help and the theme of self-care. It seems that each of these participants adapted to his or her illness and continued to develop in the recovery process in spite of setbacks.

Disclosure. A sub-theme in this study was disclosure to their employers by six participants. This sub-theme was arrived at through the van Kaam (1966) method of analysis through a listing and testing of all invariant constituents found throughout the transcripts of all interviews under the category of employment. It could be that the participants were not considering the possible negative consequences of their employer knowing about their illness. There are numerous possible reasons for disclosure. However, data analysis suggests that it is an important part in the recovery process to the point of gaining and maintaining employment due to six participants in this study engaging in this practice. All participants related that they felt a certain amount of stigma

due to their mental illness. However, only Male 6 decided to not disclose his illness due to possible stigma.

Male 6 gave his reasoning for not disclosing to his employers over the years by stating that he began employment before the ADA was passed as a law. He thought he would have been treated differently and would have been stigmatized if employers were aware of his mental illness. He also thought that even with the ADA in place, there is still discrimination in the workplace. He recommended only disclosing to employers if special accommodations are needed to perform the job tasks.

Female 1 shared some experiences of her encounters with social stigma of her illness and how this affected her throughout high school and still affected her as an adult. She related she had few friends and had not had a romantic relationship. She stated that her peers never asked her to go out with them. She attributed this to her mental illness as perceived by others.

Stigma

Research indicates that schizophrenia carries some of the most profound stigma of any mental illness (Lauber, Carlos, and Wulf, 2005). Rutman (1994) considers stigma toward persons with a mental illness in our society as affecting a person's opportunities for employment. He concludes by stating that stigma toward persons with mental illness is present at many levels in our society and adversely affects opportunities for employment of those persons. These findings could be supported by Male 6's ideas concerning disclosure of one's mental illness to employers and Male 5's experiences during the interviews he had while unemployed. In those interviews, Male 5 disclosed his

mental illness and did not gain employment. However, Male 3's mental illness was known to his employer at the time of hire, as was Male 1's. It should be noted that both Males 1 and 3 were employed in the mental health field.

Male 2 expressed what could be interpreted as stigma by coworkers who knew of his mental illness. The harassment he felt in the workplace could have been a form of stigma. Male 4, however, chose to be open in his journalism employment post hire in relation to his mental illness and did not feel that he was the victim of stigma. Female 1 did not feel stigma in the employment arena but she most certainly felt it in her social life. Female 2 did not feel stigma at work but perceived stigma to be a part of her professors' view of her and her absences from class.

Two participants reported a perception of social stigma and three in the workplace. However, only one participant, Male 2, related what he perceives as ongoing stigma in his present workplace. Male 5's interview experiences would tend to support the findings of Rutman (1994). Stigma is a sub-theme under the main theme of employment issues and the category of employment. It seems to be common in the life experiences of many of the participants in this study.

It is this researcher's perception that none of the eight participants displayed marked negative symptoms of either schizophrenia or schizoaffective disorder. From their answers to the question regarding symptoms occurring in the workplace, they all related experiencing positive rather than negative symptoms. This could give support to the findings of Solinski, Jackson, and Bell (1992); Johnstone (1991) as well as Lysaker and Bell (1995), who all found unemployment to be correlated with negative symptoms.

Support of Previous Studies

This study supports the findings of Russinova et al. (2002). In their study of 109 individuals with a self-reported diagnosis of a schizophrenia spectrum disorder, 75% of the individuals in that study had uninterrupted employment during the two years prior to entering that study. The Russinova et al. study further found that people with schizophrenia have the capacity to sustain employment at all levels, from unskilled to professional positions consistent with the findings in the present study. Two of the participants in this study were employed as computer programmers, one was a newspaper reporter, three were employed in the mental health field, and two in retail. This cross-case analysis revealed different levels of employment, and is consistent with Russinova et al.

Benefits of Employment

The benefits these eight participants found from employment are consistent with the three-tiered integrated social skills training and work module developed by Tsang (2001). That program involved 97 participants with a diagnosis of schizophrenia. The program itself evolved from the job club developed by Jacobs, Kardushian, and Krienbring (1984). The third tier is most relevant to the interpretation of the benefits each of the present study participants received from employment. Tsang focused on the following benefits of employment in this program: (a) salary, (b) structure, (c) sense of achievement, (d) personal satisfaction, and (e) the maintenance of employment. These five aspects of employment are the third tier of the Tsang program. It could be interpreted that the eight individuals in the present study also found these same benefits as important results of their respective employment experiences. The main theme revealed through

content analysis was rewards of employment, with sub-themes of intrinsic and extrinsic rewards; these were under the category of benefits. All participants related either intrinsic or extrinsic rewards arising from their employment.

Accommodations in the Workplace

The general finding to the inquiry about workplace accommodations was no accommodations asked for or received by the majority of participants. This finding led to the sub-theme of formal accommodations and the theme of employment issues within the category of employment. Accommodations seem to be unrelated to six participants' employment recovery process.

Advice to Similar Individuals

The final question that was developed in the field asked each participant if they could advise an individual with schizophrenia or schizoaffective disorder in the recovery process to the point of returning to employment of three things that are vital to that recovery. Consistent sub-themes that were revealed for advice to someone with either schizophrenia or schizoaffective disorder contemplating employment included medication compliance, finding and maintaining a support system, and beginning slowly by volunteering at something which the individual cares about. These are the same sub-themes arrived at through content analysis of the transcripts generated from the interviews of each participant.

It is this researcher's interpretation that the advice given to someone who is contemplating employment and has either disorder is a reflection of each participant's own recovery to employment process. This interpretation was evident in the question

posed to Male 3 initially. He was first asked to describe how he recovered to the point of employment and then asked to give advice to someone in similar circumstances. His responses were very similar.

Summary

In summary, the discussion relates the complex nature of the process used by each of these eight people in returning to or initially gaining employment following diagnosis. The discussion includes categories, sub-themes, and themes revealed by the van Kaam (1966) qualitative analysis method and also content analysis of the data collected. It offers interpretations of findings and discussion of how the process of gaining and maintaining employment can be viewed.

The endeavor of the van Kaam (1966) method of analysis of data and findings was to produce a multilayered and integrated synthesis. The challenge throughout the analysis was to present a voluminous amount of interview data in a reduced manner with an eye toward communicating the relevant data in view of the purpose of the study. In addition, cross and within case analysis revealed that people with either schizophrenia or schizoaffective disorder are employed at all levels in the workforce.

There are limitations of the results of this study. First the sample was small, consisting of eight participants. Second, participants all lived in the same Midwestern state. For these reasons, implications of the study are limited to the experiences of the participants.

Recognizing that the human factor is the greatest strength and also weakness of qualitative research and analysis, I recognize that the claims I make regarding

interpretations of the data are subjective to a degree although objectivity was vigorously pursued. The researcher further recognizes the potential biases related to researcher as instrument; possible additional biases arise in analyzing the findings due to my own experience with schizoaffective disorder in relation to employment.

In an effort to minimize this limitation, I have continued to engage in epoche in the process of data collection and analysis. While remaining open to the possibility that other researchers would have interpreted the data differently, this chapter is ultimately this researcher's understanding and attempt to derive meaning and connections from the data by his perceptions.

Recommendations

Given that there are different factors affecting the recovery to employment process, the recommendations made here should be considered on an individual basis. The conclusions reached could be beneficial. Therefore, recommendations are provided:

Recommendations for Mental Health and Rehabilitation Professionals

Mental health and rehabilitation professionals should consider revisiting the treatment plan goals process in assisting individuals with either schizophrenia or schizoaffective disorder and including a mutually agreed upon employment goal. This focus by mental health professionals could assist individuals with either disorder in thinking about their unique recovery to employment process. At the same time, professionals should consider implementing the Tsang (2001) three-tiered social skills module in group work with this population. This study connected the perceived rewards of the participants to the third tier of that module, which suggests the benefits of

employment. The Tsang (2001) group approach could further assist individuals with schizophrenia or schizoaffective disorder to cognitively recognize the potential rewards for striving for and obtaining employment. Furthermore, professionals should practice ongoing encouragement and inclusion of family members in the treatment process of this population if the client consents. The evidence from this study shows that families are a vital source of support and encouragement to the individuals studied. If the individual in treatment also perceives his or her family as supporting his or her treatment goals, then it seems that these goals could be enhanced. Also, professionals should consider continual contact with the individual in treatment throughout the recovery to employment process with ongoing checks on a frequent basis after the individual has entered an employment position.

Recommendations for Individuals with Schizophrenia or Schizoaffective Disorder

Find and maintain a support system which you are comfortable with and which gives you encouragement. You can benefit greatly from having a stable, ongoing support system which is a positive influence. Consider medication compliance as a vital part of recovery. Medication has been shown to reduce positive symptoms of schizophrenia and schizoaffective disorder. Educate yourself on your disorder. Learn the triggers to your individual decompensation and avoid these. Discuss employment with your personal support system and your professional support system. Once you are stable with medication and symptoms, consider volunteer work as a treatment option. Begin slowly in an effort to return to employment or gain employment for the first time. Once you have

gained employment, continue to maintain medication compliance and your support system.

Recommendations for Further Research

Further studies are recommended in the area of employment of individuals with schizophrenia or schizoaffective disorder to gain comprehensive knowledge of why and how these individuals seek employment. To this end, the following should be considered: Based on the small sample of this study and to correct for researcher bias, a larger sample of individuals in a different region than the Midwest should be conducted to determine if similar findings are discovered. A further study focusing on family support systems and how they impact the recovery to employment process with this population should be attempted. Research to determine if education levels are a factor in such individuals' ability to gain and maintain employment seems indicated. Research to determine if medication compliance is the main factor in the ability to gain and maintain employment in this population would be helpful in furtherance of knowledge of the recovery to employment process.

Researcher Reflections

As I come to the end of this study, I would like to reflect on the journey I have taken and shared with the reader. I have been able to change my level of thinking about the process of recovery to employment from where it was at the beginning of this study. My sincere hope from the beginning of this study was to change the reader's and my own level of thinking about this process through completing this research. I have accomplished the latter; the former is an unknown at this point. This study caused me to

look within myself for biases I had about mental illness in general and schizophrenia and schizoaffective disorder in particular. I feel as if I have gone through a developmental process of my own in this research study. At first, I was most interested in giving voice to individuals who have schizophrenia or schizoaffective disorder and are employed. As I experienced interviews with the participants, I came to understand that employment was more than a job to them; it was a sense of verification of their ability to function as normal people. I now believe that this desire to be perceived as normal is the driving force for most of the participants. They want and deserve to be viewed as any other individual. The fact that they have a biologically based disorder should not be a factor in evaluating their effectiveness or potential as working human beings. This study was a collaborative effort of the eight participants, my dissertation committee members, and me. As with most things in life, I have found that through giving to others I receive much more than I thought possible. It is my hope that this study gives to others who are connected to someone with schizophrenia or schizoaffective disorder in any manner. It is my further hope that this study gives to those individuals who suffer from either disorder. Through this study I have received a new perspective on employment with any type of disability.

REFERENCES

- Adams, J. E. (1991). Judicial and regulatory interpretation of the employment rights of persons with disabilities. *Journal of Applied Rehabilitation Counseling*, 22(3), 28-46.
- Ahrens, C. S., Frey, J. L., & Burke, S. C. (1999). An individualized job engagement and placement approach for persons with the most serious mental illness. *Journal of Rehabilitation*, 65(4), 17-23.
- Amador, X., & Paul-Oudouard, R. (2000). Defending the Unabomber: Anosognosia in schizophrenia. *Psychiatric Quarterly*, 71(4), 363-371.
- American Psychiatric Association (APA). (1952). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.
- American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text revision)*. Washington, DC: Author.
- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian & New Zealand Journal of Psychiatry*, 37, 586-594.
- Andrews, H., Barker, J., Pittman, J., Mars, L., Struening, E., & LaRocca, N. (1992). National trends in vocational rehabilitation: A comparison of individuals with physical disabilities and individuals with psychiatric disabilities. *Journal of Rehabilitation*, 58, 7-16.
- Anthony, W. A. (1994). The vocational recovery of people with severe mental illness: Issues and myths. *Innovations Research*, 3, 17-23.

- Anthony, W. A., Cohen, M., Farkas, M., & Gagne, C. (2005). *Recovery from mental illness: Research evidence and implications for practice, Vol. 1*. Center for Psychiatric Rehabilitation. Boston: Boston University.
- Anthony, W. A., & Liberman, R. P. (1986). The practice of psychiatric rehabilitation: Historical, conceptual and research base. *Schizophrenia Bulletin*, 12, 542–559.
- Arns, P. G., & Linney, J. A. (1993). Work, self, and life satisfaction for persons with severe and persistent mental disorders. *Psychosocial Rehabilitation Journal*, 17(2), 63–79.
- Australian Bureau of Statistics. (1998). *Transition from education to work*. Canberra, Australia: Australian Commonwealth Government.
- Badner, J. A., & Gershon, E. S. (2002). Meta-analysis of whole-genome linkage scans of bipolar disorder and schizophrenia. *Molecular Psychiatry*, 7, 405–411.
- Banks, S., Pandiana, J., Simon, M., & Tracy, B. (2003). Employment services and employment rates. Using cross-sector data to evaluate cross-sector service delivery. Paper presented at the National Conference on Mental Health Statistics, Washington, DC. Retrieved February 20, 2008, from www.mhsip.org/PandianiSimonTracyBanks2.pdf
- Barlow, D. H., & Durand, V. M. (1999). *Abnormal psychology* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Barr, C. E., Mednick, S. A., & Munk-Jorgensen, P. (1990). Exposure to influenza epidemics during gestation and adult schizophrenia: A 40 year study. *Archives of General Psychiatry*, 47, 869–874.

- Barritt, L., Beekman, T., Bleeker, H., & Mulderij, K. (1984). Analyzing phenomenological descriptions. *Phenomenology and Pedagogy*, 2(1), 1–17.
- Basset, J., Lloyd, C., & Basset, H. (2001). Work issues for young people with psychosis: Barriers to employment. *British Journal of Occupational Therapy*, 64(2), 66–72.
- Baxter, E.A., & Diehl, S. (1998). Emotional stages: Consumers and family members recovering from the trauma of mental illness. *Psychiatric Rehabilitation Journal*, 21, 349–355.
- Beard, J. H., Propst, R. N., & Malamud, T. J. (1994). The Fountain House model of psychiatric rehabilitation. In L. Spaniol, M.A. Brown, L. Blankertz, D. J. Burnham, J. Dincin, K. Furlong-Norman et al. (Eds.) *An Introduction to Psychiatric Rehabilitation* (pp. 42–52). Columbia, MD: International Association of Psychosocial Rehabilitation Services.
- Bechdolf, A., Kohn, B., Knost, B., Pukrop, R., & Klosterkotter, J. (2005). A randomized comparison of group cognitive-behavioral therapy and group psycho-education in acute patients with schizophrenia: Outcome at 24 months. *Acta Psychiatrica Scandinavica*, 112, 173.
- Becker, D. R., & Drake, R. E. (1994). Individual placement and support: A community mental health center approach to vocational rehabilitation. *Community Mental Health Journal*, 30(2), 193–206.
- Becker, D., Bond, G. R., McCarthy, D., Thompson, D., Xie, H., McHugo, G. J., & Drake, R. E. (2001). Converting day treatment centers to supported employment Programs in Rhode Island. *Psychiatric Services*, 52, 351–357.

- Becker, R. E., Miesler, N., Stormer, G., & Brodino, M. J. (1999). Employment outcomes for clients with severe mental illness in a PACT model replication. Program for assertive community treatment. *Psychiatric Services*, 50(1), 104–106.
- Bell, M. D., Lysaker, P. H., & Milstein, R. M. (1996). Clinical benefits of paid work activity in schizophrenia. *Schizophrenia Bulletin*, 22, 51–67.
- Bellack, A. S., Gold, J. M., & Buchanan, R. W. (1999). Cognitive rehabilitation for schizophrenia: Problems, perspectives, and strategies. *Schizophrenia Bulletin*, 25, 257–274.
- Blueler, E. (1911). *Dementia Praecox oder gruppe der schizophrenien*. Leipzig, Germany: Deuticke.
- Blueler, E. (1924). *Textbook of psychiatry* (A. A. Brill, Trans.). New York: Macmillan.
- Blueler, M. (1978). *The schizophrenic disorders: Long term patient and family studies*. London: Yale University Press.
- Bogdan, R. C., & Biklen, S. K. (1998). *Qualitative research for education: An introduction to theory and methods*. Needham Heights, MA: Allyn and Bacon.
- Bond, G. R., Drake, R. E., & Mueser, K. T. (1997). An update of supported employment for people with severe mental illness. *Psychiatric Services*, 48, 335–346.
- Bond, G. R., Resnick, S. G., Drake, R. E., Xie, H., McHugo, G. J., & Bebout, R. R. (2001). Does competitive employment improve nonvocational outcomes for people with severe mental illness? *Journal of Counseling and Clinical Psychology*, 69, 489–501.

- Bradbury, T. N., & Miller, G. A. (1985). Season of birth in schizophrenia: A review of evidence, methodology, and etiology. *Psychological Bulletin*, 95, 569–594.
- Brekke, J. S., Levin, S., Wolkon, G. H., Sobel, E., & Slade, E. (1993). Psychosocial functioning and subjective experience in schizophrenia. *Schizophrenia Bulletin*, 19, 599–608.
- Brown, A. S., Cohen, P., Harkavy-Friedman, J., & Babulas, V. (2001). Prenatal rubella, premorbid abnormalities, and adult schizophrenia. *Biological Psychiatry*, 49, 473–486.
- Buschbaum, M. S., & Haier, R. J. (1987). Functional and anatomical brain imaging: Impact on schizophrenia research. *Schizophrenia Bulletin*, 13, 115–132.
- Cannon, T. D. (1997). On the nature and mechanisms of obstetric influences in schizophrenia: A review and synthesis of epidemiological studies. *International Journal of Psychiatry*, 9, 387–397.
- Chaplin, J. P. (1985). *Dictionary of psychology* (2nd rev. ed.). New York: Dell Publishing.
- Chen, Y. R., Swan, A. C., & Johnson, B. A. (1998). Stability of diagnosis in bipolar disorder. *The Journal of Nervous and Mental Disease*, 186(1), 17–23.
- Ciompi, L. (1980). Catamnestic long-term study on the course of life and aging of schizophrenics. *Schizophrenia Bulletin*, 6, 606–618.
- Cohen, M. Z., Kahn, D. L., & Steeves, R. H. (2000). *Hermeneutical phenomenological research: A practical guide for nurse researchers*. Thousand Oaks, CA: Sage.

- Cohen, M., & Omery, A. (1994). Schools of phenomenology: Implications for research. In J. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 135–158). Thousand Oaks, CA: Sage.
- Creswell (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Cunningham, K., Wolbert, R., & Brockmeier, M. B. (2000). Moving beyond the illness: Factors contributing to gaining and maintaining employment. *American Journal of Community Psychology*, 28(4), 481–494.
- da Costa, D. A. (1997). The role of psychosurgery in treatment of selected cases of refractory schizophrenia: A reappraisal. *Schizophrenia Research*, 28(2–3), 223–230.
- Danley, K. S., & Anthony, W. A. (1987). The choose-get-keep model: Serving severely psychiatrically disabled people. *American Rehabilitation*, 13(4), 27–29.
- Davidson, L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: New York University Press.
- Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65, 131–145.
- Davidson, L. (1993). Story telling and schizophrenia: Using narrative structure in phenomenological research. *The Humanistic Psychologist*, 21, 200–220.
- Denzin, N. K. (1989). *Interpretive interactionism*. Newbury Park, CA: Sage.

- Drake, R., Fox, T. S., Leather, P. K., Becker, D. R., Musumeci, J. S., Ingram, W. F., et al. (1998). Regional variation in competitive employment for persons with severe mental illness. *Administration and Policy in Mental Health*, 25, 493–504.
- Eklund, M., Hansson, L., & Bejerholm, U. (2001). Relationships between satisfaction with occupational factors and health-related variables in schizophrenia outpatients. *Social Psychiatry Psychiatric Epidemiology*, 36, 79–85.
- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, 36, 717–732.
- Freedman, R. (2005). The choice of antipsychotic drugs for schizophrenia. *The New England Journal of Medicine*, 353, 1286–1288.
- Gaudino, B. A. (2006). Is symptomatic improvement in clinical trials of cognitive behavioral therapy for psychosis clinically significant? *Psychiatric Practice*, 12(1), 11–18.
- Geertsen, D., Davis, S., & Ellis, R. (2002). Sixteen-state study on mental health performance measures: Employment status and change in employment after services. Paper presented at the National Conference on Mental Health Statistics, Washington, D.C. Retrieved March 7, 2008, from <http://www.mhsip.org/DennisGeertsen02.pdf>

- Gold, J. M., Queern, C., Iannone, V. N., & Buchanan, R. W. (1999). Repeatable battery for the assessment of neuropsychological status as a screening test in schizophrenia II: Convergent/discriminant validity and diagnostic group comparisons. *American Journal of Psychiatry*, 156, 1944–1950.
- Goldberg, R. W., Lucksted, A., McNary, S., Gold, J. M., Dixon, L., & Lehman, A. (2001). Correlates of long-term employment among inner-city adults with serious and persistent mental illness. *Psychiatric Services*, 52, 101–103.
- Gottesman, I. (1991). *Psychiatric genesis: The origins of madness*. New York: Freeman.
- Gould, R. A., Mueser, K. T., & Bolton, E. (2001). Cognitive therapy for psychosis in schizophrenia: An effect size analysis. *Schizophrenia Research*, 48, 335–342.
- Hafner, H., Maurer, K., Löffler, W., an der Heiden, W., Hambrecht, M., & Schultze-Lutter, F. (2003). Modeling the early course of schizophrenia. *Schizophrenia Bulletin*, 29, 325–340.
- Harding, C. M., & Zahniser, J. H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Scandinavica*, 90, 140–146.
- Harding, C. M., Brooks, G. W., Ashinkaga, T., Strauss, J.S., & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness: Methodology, study sample, and overall status 32 years later. *American Journal of Psychiatry*, 144, 718–726.
- Harding, C. M., Zubin, J., & Strauss, J. S. (1992). Chronicity in schizophrenia: Revisited. *British Journal of Psychiatry*, 161, 27–37.

- Haslam, J. (1809). *Observations on madness and melancholy: Including practical remarks on those diseases together with cases, and an account of the morbid appearances on dissection*. 2nd Ed. London: J. Callow.
- Hoffer, A., & Pollin, W. (1970). Schizophrenia in the NAS-NRC panel of 15,909 veteran twin pairs. *Archives of General Psychiatry*, 23, 469–477.
- Huber, G., Gross, G., & Schuttler, R. (1980). A long-term follow-up study of schizophrenia: Psychiatric course of illness and prognosis. *Acta Psychiatrica Scandinavica*, 52, 49–57.
- Husserl, E. (1970). *Logical investigations* (J. N. Findlay, Trans.; Vol. 1). New York: Humanities Press.
- Jablensky, A., McGarth, J., & Herrman, H. (1999). *National Survey of mental health and well being, report 4: People living with psychotic illness*. Canberra, Australia: Australia Commonwealth Department of Health and Aged Care.
- Jacobs, H. E., Kardushian, S., & Krienbring, R. H. (1984). A skills-oriented model for facilitating employment among psychiatrically disabled persons. *Rehabilitation Counseling Bulletin*, 28, 87–96.
- Jacobsen, N., & Greenley, D. (2001). What is recovery? A concept model and explanation. *Psychiatric Services*, 52, 482–485.
- Johnstone, E.C., (1991). Disabilities and circumstances of schizophrenic patients: A follow-up study. *British Journal of Psychiatry*, 159, 46.

- Keefe, R.S., Young, C.A., Rock, S.L., Purdon, S.E., Gold, J.M., Breier, A., & HGGN Study Group. (2006). One-year double-blind study of the neurocognitive efficacy of loanzapine, risperidone, and haloperidol in schizophrenia. *Schizophrenia Research, 61*, 1-15.
- Kingdon, D. G., & Turkington, D. (2005). *Cognitive therapy of schizophrenia*. New York: Guilford.
- Kirsch, B. (2000). Factors associated with employment for mental health consumers. *Psychiatric Rehabilitation Journal, 21*(1), 13–21.
- Klien, T. W., & Westcott, M. R. (1994). The changing character of phenomenological Psychology. *Canadian Psychology, 35*(2), 133–157.
- Koskenvuo, M., Langinvainio, H., Kaprio, J., Lonnqvist, J., & Tienari, P. (1984). Psychiatric hospitalization in twins. *Acta Geneticae Medicae et Gemellologiae (Roma), 33*, 321–332.
- Kraepelin, E. (1912). *Clinical psychiatry: A textbook for students and physicians* (rev. ed., A. R. Diefendorf, Trans.). New York: McMillan.
- Knisley, M.B., Hyde, P.S., & Jackson, E. (2003). Involvement of state and local mental health authorities in addressing the employment needs of people with serious mental illness. *Sourcebook of Rehabilitation and Mental Health Practices*. New York: Kluwer Academic/Plenum Publishers.
- Kruger, A. (2000). Schizophrenia and hope. *Psychiatric Rehabilitation Journal, 24*(1), 29–39.

- Krupa, T. (2004). Employment, recovery, and schizophrenia: Integrating health and disorder at work. *Psychiatric Rehabilitation Journal*, 28, 8-15.
- Lauber, C., Carlos, N., & Wulf, R. (2005). Lay beliefs about treatment for people with mental illness and their implications for antistigma strategies. *Canadian Journal of Psychiatry*, 50, 745-752.
- Leff, H. S., Cook, J. A., Gold, P. B., Toprac, M., Blyler, C., Goldberg, R. W., et al. (2005). Effects of job development and job support on competitive employment of persons with severe mental illness. *Psychiatric Services*, 56, 1237–1244.
- Lehman, A. F., Goldberg, R., Dixon, L. B., McNary, S., Postrado, L., Hackman, A., et al. (2002). Improving employment outcomes for persons with severe mental illnesses. *Archives of General Psychiatry*, 59, 165–172.
- Lehman, A., Steinwachs, D., & PORT Co-Investigators. (1998). Patterns of usual care for schizophrenia: Initial results from the schizophrenia patient outcomes research team (PORT) survey. *Schizophrenia Bulletin*, 24, 13–21.
- Leinbaugh, T. (2001). Electroconvulsive therapy: A primer for mental health counselors. *Journal of Mental Health Counseling*, 23(1), 36–47.
- Leo, J. (2003). The fallacy of the 50% concordance rate for schizophrenia in identical twins. *Human Nature Review*, 3, 406–415.
- Liberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, 14, 256–272.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills: Sage.

- Lopez, S. R., Hipke, K. N., Polo, A. J., Kano, M., Jenkins, J. H., Vaughn, C., & Snyder, K.S. (2004). Ethnicity, expressed emotion, attributions, and course of schizophrenia. *Journal of Abnormal Psychology, 113*, 428-439.
- Lord, J., Schnarr, A., & Hutchinson, P. (1987). The voice of the people: Qualitative research and the needs of consumers. *Canadian Journal of Community Mental Health, 6*, 25–36.
- Luborsky, M., & Rubinstein, R. (1995). Sampling in qualitative research. *Research on Aging, 17*, 89-117.
- Lysaker, P., & Bell, M. (1995). Work rehabilitation and improvements in insight in schizophrenia. *Journal of Nervous and Mental Disorders, 183*(2), 103–106.
- Marshall, C., & Rossman, G. B. (1995). *Designing qualitative research* (2nd ed.) Thousand Oaks, CA: Sage.
- Marwaha, S., & Johnson, S. (2004). Schizophrenia and employment: A review. *Social Psychiatry Psychiatric Epidemiology, 39*, 337–349.
- Maxwell, J. A. (1996). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: Sage.
- McGurk, S. R., & Meltzer, H. Y. (2000). The role of cognition in vocational functioning in schizophrenia. *Schizophrenia Research, 45*, 175–184.
- McGurk, S. R., & Meuser, K. T. (2004). Cognitive functioning, symptoms, and work in supported employment: A review heuristic model. *Schizophrenia Research, 70*, 147–173.

- McGurk, S. R., Meuser, K. T., Harvey, P. D., Marder, J., & LaPuglia, R. (2003). Cognitive and symptom predictors of work outcomes for clients with schizophrenia in supported employment. *Psychiatric Services*, 54, 1129–1135.
- Meltzer, H. Y., & McGurk, S. R. (1999). The effects of clozapine, risperidone, and olanzapine on cognitive function in schizophrenia. *Schizophrenia Bulletin*, 25, 233–255.
- Miller, J. F. (1992). *Coping with chronic illness: Overcoming powerlessness* (2nd ed.). Philadelphia: F. A. Davis.
- Morse, J. M. (1989). Strategies for sampling. In J. M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 117–132). Rockville, MD: Aspen Publications.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Mowbray, C. T., Moxley, D. P., & Jasper, C. A. (Eds.). (1997). *Consumers as providers in psychiatric rehabilitation*. Linthicum, MD: International Association of Psychosocial Rehabilitation Services.
- Mowry, B. J., & Nancarrow, D. J. (2001). Molecular genetics of schizophrenia. *Clinical and Experimental Pharmacology and Physiology*, 28, 66–69.
- Mueser, K. T., Aalto, S., Becker, D. R., Ogden, J. S., Wolfe, R. S., Schiavo, D., et al. (2005). The effectiveness of skills training for improving outcomes in supported employment. *Psychiatric Services*, 56, 1254–1260.

- Mueser, K. T., Becker, D., Torrey, W. C. M., Xie, H., Bond, G., Drake, R., et al. (1997). Work and non-vocational domains of functioning in persons with severe mental illness: A longitudinal analysis. *Nervous & Mental Disorders*, 185, 419–426.
- Mueser, K. T., Salyers, M. P., & Mueser, P. R. (2001). A prospective analysis of work in schizophrenia. *Schizophrenia Bulletin*, 27, 281–296.
- Murphy, M. A. (1998). Rejection, stigma, and hope. *Psychiatric Rehabilitation Journal*, 22, 186–188.
- National Institute of Mental Health (2005). *Mental Health Statistics*. Retrieved March 13, 2005, from www.nimh.nih.gov/health/topics/statistics/index.shtml
- Novalis, P. N., Rojcewicz, S. J., & Peele., R. (1993). *Clinical manual of supportive psychotherapy*. Washington, DC: American Psychiatric Press.
- O’Keffe, J. (1994). Disability, discrimination, and the Americans With Disabilities Act. In S. M. Bruyere & J. O’Keffe (Eds.). *Implications of the Americans With Disabilities Act for psychology*. New York: Springer.
- Olsheski, J., & Schelat, R. (2003). Reasonable job accommodations for people with psychiatric disabilities. In D. P. Moxley & J. R. Finch (Eds.), *Sourcebook of rehabilitation and mental health practice* (pp. 61–76). New York: Kluwer Academic Publishers.
- Osborne, J. Q. (1994). Some similarities and differences among phenomenological and other research methods of psychological qualitative research. *Canadian Psychology*, 35(2), 167–189.

- Palmer, B., Heaton, R., Gladsjo, J., Evans, J., Patterson, T., Golshan, S., Shahrok, H., Jeste, Dilip V. (2002). Heterogeneity in functional status among older outpatients with employment history, living situation and driving. *Schizophrenia Research*, 55, 205–215.
- Pardeck, J. T. (1999). Psychiatric disabilities and the American With Disabilities Act: Implications for policy and practice. *Journal of Health and Social Policy*, 10(3), 1–12.
- Patton, M. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.
- Peckham, J., & Muller, J. (1999). Employment and schizophrenia: recommendations to improve employability for individuals with schizophrenia. *Psychiatric Rehabilitation Journal*, 22(4), 399–402.
- Pettie, D., & Triolo, A. M. (1999). Illness as evolution: The search for identity and meaning in the recovery process. *Psychiatric Rehabilitation Journal*, 22, 255–262.
- Pilling, P., Bebbington, P., & Kuipers, E. (2002). Psychological treatments in Schizophrenia: Meta-analysis of family interventions and cognitive-behavioral therapy. *Psychological Medicine*, 32, 763–782.
- Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience* (pp. 41–60). New York: Plenum.

- Popay, J., Rogers, A., & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8, 341–351.
- Pratt, C. W., Gill, K. J., Barnett, N. M., & Roberts, M. M. (1999). *Psychiatric Rehabilitation*. New York: Academic.
- Ram, R., Bromet, E. J., Eaton, W. W., Pato, C. & Schwartz, J. E. (1992). The natural natural course of schizophrenia: A review of first-admission studies. *Schizophrenia Bulletin*, 18, 185–207.
- Regenold, M., Sherman, M., & Fenzel, M.(1999). Getting back to work: Self efficacy as a predictor of employment outcome. *Psychiatric Rehabilitation Journal*, 25, 53–59.
- Rehabilitation Act Amendments of 1998, Pub. L. No. 105–200, § 794 (d) Stat, 936 (1998).
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. South Melbourne, Victoria, Australia: Oxford University Press.
- Roberts, M., & Rotteveel, J. (1995). Stigma in the workplace. Paper presented at the 6th Annual Association for Persons in Supported Employment Conference, Denver.
- Roder, V., Jenull, B, & Brenner, H. D. (1998). Teaching schizophrenic patients recreational, residential and vocational skills. *International Review of Psychiatry*, 10(1), 35–41.

- Rogers, L., & Kegan, R. (1991). *Mental growth and mental health as distinct concepts in the study of developmental psychopathology: Theory, research, and clinical implications. Constructivist perspectives on developmental psychopathology and atypical development*. Hillsdale, NJ: Lawrence Erlbaum Assoc.
- Rubin, S. E., & Roessler, R. T. (1995). *Foundations of the vocational rehabilitation process*. Austin, TX: Pro-Ed.
- Russinova, Z., Ellison, M., & Foster, R. (1999). Survey of professionals and managers with psychiatric disabilities. Paper presented Association for Persons in Supportive Rehabilitation Services 24th annual conference, Minneapolis, MN.
- Russinova, Z., Wewiorski, N. J., Lyass, A., Rogers, E. S., & Massaro, J. M. (2002). Correlates of vocational recovery for persons with schizophrenia. *International Review of Psychiatry*, 14, 303–311.
- Rutman, E. D. (1994). How a psychiatric disability expresses itself as a barrier to employment. *Psychosocial Rehabilitation Journal*, 17(3), 15–35.
- Salkever, D. S., Slade, E. P., & Karakus, M. C. (2006). Employment retention by persons with schizophrenia employed in non-assisted jobs. *Journal of Rehabilitation*, 69(4), 19–26.
- Schuldberg, D., Quinlan, D. M., & Glazer, W. (1999). Positive and negative symptoms and adjustment in severely mentally ill outpatients. *Psychiatry Research*, 85(2), 177–188.

- Secker, J., Gove, B., & Seebohm, P. (2001). Challenging barriers to employment, training and education for mental health service users: The service user's perspective. *Journal of Mental Health (UK)*, 10, 395–404.
- Sheldrick, R.C., Kendall, P.C., & Heimberg, R.G. (2001). The clinical significance of treatments in comparison of three treatments for conduct disordered children. *Clinical Psychology: Science and Practice*, 8, 418–430.
- Snyder, C. R., Michael, S. T., & Cheavens, J. S. (1999). Hope as a psychotherapeutic foundation of common factors, placebos and expectancies. In M. A. Hubble, B. Duncan, S. Miller (Eds.), *Heart and Soul of Change* (pp.179 –200). Washington, DC: American Psychological Press.
- Social Security Administration. (1995). *Red book on work incentives. A summary guide to Social Security and Supplemental Security Income: Work incentives for people with disabilities*. Washington, DC: Social Security Administration Office of Programs. (SSA Pub. No. 64-030)
- Solinski, S., Jackson, H. J., & Bell, R. C. (1992). Prediction of employability in schizophrenic patients. *Schizophrenia Research*, 7, 141–148.
- Spaniol, L., Wewiorski, N., Gagne, C., & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry*, 14, 327–336.
- Spiegelberg, H. (1982). *The phenomenological moment* (3rd ed.). The Hague, The Netherlands: Martinus Nijhoff.
- Steeves, R. H., & Kahn, D. H. (1994). Family perspectives: The tasks of bereavement. *Quality of Life—A Nursing Challenge*, 3(3), 48–53.

- Super, D. E. (1990). A life-span, life-space approach to career development. In D. Brown, L. Brooks, & Associates (Eds.), *Convergence in career development theories* (pp. 63–71). Palo Alto, CA: Counseling Psychologists Press.
- Thompson, K., McGorry, P., & Harrigan, S. (2003). Recovery style outcome in first-episode psychosis. *Schizophrenia Research*, 62, 31–36.
- Tienari, P. (1963). *Psychiatric illness in identical twins*. Copenhagen, Denmark: Munsgaard.
- Tienari (1968) Schizophrenia in monozygotic twins. In D. Rosenthal & S. Kety (Eds.), *The transmission of schizophrenia* (pp. 27–36). New York: Pergamon.
- Tienari, P. (1971). Schizophrenia and monozygotic twins. *Psychiatria Fennica*, 1971, 97–104.
- Tienari, P. (1975). Schizophrenia in Finnish male twins. In M. H. Lader (Ed.), *British Journal of Psychiatry Special Publication*, 10 (pp. 29–35).
- Torrey, E.F., Bowels, A.E., & Clark, K. (1997). Urban birth and residence as risk factors for psychoses: An analysis of 1980 data. *Schizophrenia Research*, 25, 169-176.
- Tsang, H. W. (2001). Rehab rounds: Social skills training to help mentally ill persons find and keep a job with schizophrenia in Hong Kong. *Schizophrenia Bulletin*, 27, 139–148.
- Tsuang, M. T., Woolson, R. F., & Fleming, J. A. (1979). Long-term outcome of major psychoses: Schizophrenia and affective disorders compared with psychiatrically free surgical symptoms. *Archives of General Psychiatry*, 36, 1295–1301.

- U.S. Equal Opportunity Commission. (1992). A technical assistance manual on the employment provisions (Title I) of the Americans with Disabilities Act. Washington, DC: Author.
- Van Dongen, C. J. (1996). Quality of life and self-esteem in working and non-working persons with mental illness. *Community Mental Health Journal*, 32, 535–548.
- van Kaam, A. (1966). Application of the phenomenological method. In A. van Kaam, *Existential foundations of psychology* (pp. 294–329). Lanham, MD: University Press of America.
- Waghorn, G., Chant, D., & Whiteford, H. (2003). The strength of self-reported course of illness in predicting vocational recovery for persons with schizophrenia. *Journal of Vocational Rehabilitation*, 18, 33–41.
- Walker, E., Kestler, L., Bollini, A., & Hochman, K. M. (2004). Schizophrenia: Etiology and course. *Annual Review of Psychology*, 55, 401–430.
- West, P. (1993). Americans With Disabilities Act of 1990. 42 U.S.C.A. §12101 et seq.
- Westermeyer, J.F., & Harrow, M. (1987). *Prognosis in schizophrenia. Research in schizophrenia: A multidimensional approach*. Springfield, IL: Charles C. Thomas.
- Weisman, D., Neinhaus, F. J., Slooff, C. J., & Geil, R. (1998). Natural course of schizophrenic disorders: A 15-year follow-up of a Dutch incidence cohort. *Schizophrenia Bulletin*, 24(1), 75–85.
- Wyatt, R. (2005). Schizophrenia facts and statistics. Retrieved February 23, 2006, from www.schizophrenia.com/szfacts.htm

- Young, S. L., & Ensing, D. S. (1999). Exploring recovery from the perspectives of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 22, 219–231.
- Zimmerman, G., Favrod, J., Trieut, V. H., & Pomini, V. (2005). The effect of cognitive behavioral treatment on the positive symptoms of schizophrenia spectrum disorders: A meta-analysis. *Schizophrenia Research*, 77, 1–9.

APPENDIX A: DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1. What is your gender? Male___ Female___
2. What is your marital status?
Single___Married___Divorced___Widowed___
Partnered___
3. What is your ethnicity? White___African American___
Hispanic___American Indian___ Asian___ Other___
4. What is your educational level? K-8___high school___ college___
postgraduate work___post graduate degree___
5. What is your approximate age range? 18-25___ 25-35___ 35-45___
45-55___ 55-65___ 65-75___ 75 and above___
6. What is your annual income? Less than \$10,000___
\$10-15,000___\$15-20,000___\$20,000-25,000___
\$ 25-30,000___\$ 30-35,000___\$35-40,000___ \$40-45,000 ___
\$45-50,000___\$ 50-55,000___\$55-60,000___ \$60-65,000___
\$65-70,000___ \$70-75,000___\$75-80,000___ \$80-85,000___
\$85- 90,000___ \$ 90-95,000___\$95-100,000___
Over \$100,000___

APPENDIX B: RESEARCH QUESTIONS

Research Questions

I endeavored to incorporate most of the aspects of recovery found in the literature in the following questions asked during the first interview:

1. What does recovery mean to you?
2. Has that changed over time?
3. Did you have any supports in returning to employment?
4. Did you have any services in returning to employment?
5. Do you take any medications for your mental illness? If so, do you take the medications regularly?
6. How did you identify services available to you?
7. Did anyone assist you in returning to employment? Who?
8. If you have a support system, did they have an influence on your decision to return to work?
9. What has been your experience with your employer?
10. Were there any problems with your employment? What? What did you do?
11. Did you experience failure at any time during your attempt to return to employment? How did it affect you?
12. How do you handle stress at work?

APPENDIX C: OHIO UNIVERSITY CONSENT FORM

Ohio University Consent Form

OHIO UNIVERSITY

INSTITUTIONAL REVIEW BOARD

Title of Research: What Process Have Individuals With Schizophrenia Or
Schizoaffective Disorder Found Effective In Returning To Or Initially Securing
Employment Following Diagnosis

Principal Investigator: Willard A Sheets, M Ed., NCC, PCC-S

Co-Investigator: N/A

Department: Counseling and Higher Education

Federal and university regulations require signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

Explanation of Study

The purpose of this study is to ask you about the process you used to gain and maintain employment following diagnosis with either schizophrenia or schizoaffective disorder. You will be asked a series of questions related to your recovery from either schizophrenia or schizoaffective disorder to the point of returning to or initially securing employment following diagnosis. There will be a total of three digitally audio recorded interviews each lasting approximately one hour. However, if you choose to talk for longer than one hour for each interview, it will be greatly appreciated. Each interview session will be transcribed by a professional transcriptionist hired by the researcher. A

comparison of the printed transcript by the researcher with the recorded audio information will then take place.

You are encouraged to verify that what you meant to say during the interview is present in the transcribed document. If you think an error in meaning or content has occurred you are further encouraged to discuss this with the researcher and assist him in making the needed changes. Every attempt will be made to schedule the first, second, and third interviews at a time and place that is convenient for you and provides for maximum privacy. If you choose to discontinue participation at any time prior to or during any of the interviews, you may do so without penalty.

Risks and Discomforts

I understand that if at any time I am uncomfortable with the interview I am free to leave. I understand that there is a minimal risk that I may become emotionally upset discussing my recovery from either schizophrenia or schizoaffective disorder to the point of returning to or initially gaining employment. I further understand that the researcher is a trained counselor and will be monitoring my emotional state throughout the interviews. If I or the researcher considers it necessary, I will be referred to a local community mental health center or my case manager in my geographic location for treatment.

Benefits

I understand that my participation in this study will provide information on the issue of returning to or initially securing employment following a diagnosis of either schizophrenia or schizoaffective disorder. This information will not directly benefit but may lead to new insight into this issue.

Confidentiality and Records

I understand that the interviews will be digitally recorded and the conversations will be erased following transcription. I also understand that a random numeric code will be developed by the researcher following the first interview to insure my anonymity in the typed transcriptions. My real name will only be known to myself and the researcher in relation to this study. The transcripts of the interviews and the digital recording prior to transcription will be stored in a locked file cabinet in the researcher's office, which is locked when he is not there. My real name and the numeric code will be destroyed by the researcher following my verification that the transcript contains information as I have intended it to be described. Confidentiality will be maintained by the researcher with no one other than the researcher having access to my real name in relation to the study, except in the event that it becomes clear to the researcher in the course of any interview that you are describing child abuse, elder abuse, suicidal or homicidal ideation, confidentiality must be legally and ethically broken with such circumstances as described being reported to the proper authorities by the researcher.

Compensation

I understand that at the completion of each of three interviews I will be provided with a twenty dollar (\$20.00) gift certificate to a local restaurant of my choice. In the event that I do not complete an interview fully, I further understand that I will still receive the gift certificate in the amount of \$20.00. I further understand that the gift certificate is given in appreciation for my time and effort in the interview.

Contact Information

If you have any questions regarding this study, please contact Willard A. Sheets, M.Ed., NCC, PCC at my office, (740) 441-8953, or e-mail me at sheetsw@sbcglobal.net or Dr. Leinbaugh at her office, (740)593-0846, or e-mail her at leinbaugh@ohio.edu.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature_____Date_____

Printed Name_____

APPENDIX D: RECRUITMENT TOOL – LETTER TO COMMUNITY MENTAL
HEALTH PROVIDER

Dear Community Mental Health Provider,

My name is Willard A. Sheets. I am currently a PhD Student at Ohio University engaged in developing a dissertation research project titled: What Process Have Individuals with Schizophrenia or Schizoaffective Disorder Found Effective in Returning to or Initially Securing Employment Following Diagnosis. This study is qualitative in design. This design will require that I recruit eight to 12 individuals from Ohio and interview these individuals verbally. They will be provided with a twenty-dollar gift certificate to a local restaurant of their choice following each interview as appreciation for their time and effort.

There will be three interviews lasting approximately one hour each. Each interview will be digitally recorded so I can analyze and compare the responses of participants, but strict confidentiality is maintained. True names will not appear in literature published about this study and tapes are erased after verification with transcription. The criteria for participation in these interviews are that the individual has been diagnosed with either schizophrenia or schizoaffective disorder within the past 15 years, has not been hospitalized for their illness within the past year, and has worked for at least six months in the past two years for at least 10 hours per week.

I am including with this document a copy of the Institutional Review Board of Ohio University's approval of the proposed research, and a copy of my dissertation committee-approved proposal for your consideration. Also included are copies of the

demographic questionnaire and list of initial questions for the participants. I am requesting the attached flyer be placed in a high traffic area in your organization's facility. If there is a charge for such a posting, I am more than willing to provide compensation accordingly.

It is my hope that by analyzing the common and diverse themes in each individual's experience of the phenomenon of returning to or initially securing employment following diagnosis with either disorder, a greater understanding and potential enhancement of theory in the area of employment as a treatment goal can be facilitated. Your potential assistance in this study is greatly appreciated.

Sincerely,

Willard A. Sheets, M.Ed., NCC, PCC 740-441-8953 or sheetsw@sbcglobal.net

APPENDIX E: RECRUITMENT TOOL – LETTER TO NAMI OHIO

Dear NAMI Ohio Director,

My name is Willard A. Sheets. I am currently a PhD Student at Ohio University engaged in developing a dissertation research project titled: What Process Have Individuals with Schizophrenia or Schizoaffective Disorder Found Effective in Returning to or Initially Securing Employment Following Diagnosis. This study is qualitative in design. This design will require that I recruit eight to 12 individuals from Ohio and interview these individuals verbally. They will be provided with a twenty-dollar gift certificate to a local restaurant of their choice following each interview as appreciation for their time and effort

There will be three interviews lasting approximately one hour each. Each interview will be digitally recorded so I can analyze and compare the responses of participants, but strict confidentiality is maintained. True names will not appear in literature published about this study and tapes are erased after verification with transcription. The criteria for participation in these interviews are that the individual has been diagnosed with either schizophrenia or schizoaffective disorder within the past 15 years, has not been hospitalized for their illness within the past year, and has worked for at least six months in the past two years for at least 10 hours per week.

I am including with this document a copy of the Institutional Review Board of Ohio University's approval of the proposed research, and a copy of my dissertation committee-approved proposal for your consideration. Also included are copies of the demographic questionnaire and list of initial questions for the participants.

I am requesting upon your approval, a listing of the attached recruitment flyer in your organization's newsletter and on your organization's website. If there is a charge for this privilege, I am more than willing to compensate your organization accordingly. It is my hope that by analyzing the common and diverse themes in each individual's experience of the phenomenon of returning to or initially securing employment following diagnosis with either disorder, a greater understanding and potential enhancement of theory in the area of employment as a treatment goal can be facilitated. Your potential assistance in this study is greatly appreciated. I can be reached by phone at (740) 441-8953, by e-mail at sheetsw@sbcglobal.net, and by U.S. mail at Willard A. Sheets, 156 2nd Avenue, Gallipolis, Ohio 45631.

Sincerely,

Willard A. Sheets, M.Ed., NCC, PCC 740-441-8953 or sheetsw@sbcglobal.net

APPENDIX F: RECRUITMENT TOOL – LETTER TO OHIO ADVOCATES FOR
MENTAL HEALTH

Dear Ohio Advocates for Mental Health Director,

My name is Willard A. Sheets. I am currently a PhD student at Ohio University engaged in developing a dissertation research project titled: What Process Have Individuals with Schizophrenia or Schizoaffective Disorder Found Effective in Returning to or Initially Securing Employment Following Diagnosis. This study is qualitative in design. This design will require that I recruit eight to 12 individuals from Ohio and interview these individuals verbally. They will be provided with a twenty-dollar gift certificate to a local restaurant of their choice following each interview as appreciation for their time and effort

There will be three interviews lasting approximately one hour each. Each interview will be digitally recorded so I can analyze and compare the responses of participants, but strict confidentiality is maintained. True names will not appear in literature published about this study and tapes are erased after verification with transcription. The criteria for participation in these interviews are that the individual has been diagnosed with either schizophrenia or schizoaffective disorder within the past 15 years, has not been hospitalized for their illness within the past year, and has worked for at least six months in the past two years for at least 10 hours per week.

I am including with this document a copy of the Institutional Review Board of Ohio University's approval of the proposed research, and a copy of my dissertation

committee-approved proposal for your consideration. Also included are copies of the demographic questionnaire and list of initial questions for the participants.

I am requesting upon your approval, a listing of the attached recruitment flyer in your organization's newsletter and on your organization's website. If there is a charge for this privilege, I am more than willing to compensate your organization accordingly. It is my hope that by analyzing the common and diverse themes in each individual's experience of the phenomenon of returning to or initially securing employment following diagnosis with either disorder, a greater understanding and potential enhancement of theory in the area of employment as a treatment goal can be facilitated. Your potential assistance in this study is greatly appreciated. I can be reached by phone at (740) 441-8953, by e-mail at sheetsw@sbcglobal.net, and by U.S. mail at Willard A. Sheets, 156 2nd Avenue, Gallipolis, Ohio 45631.

Sincerely,

Willard A. Sheets, M.Ed., NCC, PCC 740-441-8953 or sheetsw@sbcglobal.net

APPENDIX G: ADVERTISEMENT FLYER

Schizophrenia/Schizoaffective sufferers: If you have been diagnosed with either Schizophrenia or Schizoaffective Disorder within the last 15 years and have been employed for at least six months in the past two years I would like to include your experiences in gaining and maintaining employment in a research study that I am conducting for my dissertation. Please feel free to contact me at sheetstw@sbcglobal.net or call (740) 441-8953 collect. Please help further understanding of these mental disorders and employment. Thank you very much.

APPENDIX H: PARTICIPANT SCREENING SCRIPT AND QUESTIONS

You are going to be asked a series of questions that will determine if you meet criteria to be included as a participant in the study titled, “What Process Have Individuals with Schizophrenia or Schizoaffective Disorder Found Effective in Returning to or Initially Securing Employment Following Diagnosis.” These questions should take approximately 10 minutes to answer. There is a slight risk that you may become upset answering these questions. If you become overly upset after answering these questions, a phone number to the local community mental health hotline in your area will be provided and is listed below. As a researcher and Licensed Clinical Counselor, I am obligated to report certain activities to appropriate authorities. If during these series of questions it becomes apparent that you are intending to do harm to yourself, or anyone else, the appropriate authorities in your area will be notified, as well as the potential victim. Also, if during these series of questions it becomes apparent that you are describing child abuse or elder abuse, the appropriate authorities in the area(s) the victim and abuser resides will be notified.

Jackson County, Ohio, Woodland Centers, Inc. 1-800-252-5554

Athens, Vinton, and Hocking Counties, Ohio, Tri-County Mental Health
1-888-475-8484

Scioto County, Ohio, Shawnee Mental Health 1-800-448-2273

Muskingum, Guernsey, Morgan, Perry, Coshocton, Noble, Counties, Ohio, Six County
Mental Health 1-800-344-5818

Pike, Ross, Pickaway, Highland, Fayette Counties, Ohio, Scioto Paint Valley Mental
Health 1-740-947-2147

A list of screening questions asked of potential participants follows:

1. Have you been diagnosed with either Schizophrenia or Schizoaffective Disorders in the past 15 years?
2. If you have been diagnosed with either Schizophrenia or Schizoaffective Disorders in the past 15 years, have you been hospitalized for the disorder in the past year?
3. If you have not been hospitalized for the disorder(s) in the past year and have been diagnosed for the disorder in the past 15 years, have you been employed for at least six months in the past two years?
4. If you have been employed for at least six months in the past two years, have been diagnosed for either disorder in the past 15 years, and have not been hospitalized for either disorder in the past year, has your employment been at a level of at least 10 hours per week?
5. How do you function in your relationships with family, friends, and coworkers?
6. How much of a problem, if any, do you have with symptoms of your illness?