A Qualitative Investigation of Individual and Contextual Factors Associated With Vocational Recovery Among People With Serious Mental Illness

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Most people with serious mental illness (SMI) experience difficulty in fulfilling a vocational role, with many being unemployed or underemployed. Given the profound social and economic costs of this level of work impairment, researchers have investigated ways to enhance "vocational recovery," or the processes through which people with SMI regain their role as workers and reintegrate into the workforce. Using data collected from a larger qualitative study of 23 individuals who had progressed to an advanced stage of recovery from SMI, this study explored respondents' perspectives on employment and its relationship to their vocational recovery. Text passages describing employment were analyzed inductively by a diverse team of researchers. Seven themes were identified as being important in helping participants return to work or remain employed following the onset of a serious psychiatric disability: having the confidence to work, having the motivation to work, possessing work-related skills, assessing person–job fit, creating work opportunities, receiving social support, and having access to consumer-oriented programs and services. Implications of these findings on the development of interventions and policies to improve the vocational outcomes of people with SMI are discussed.

Between 3.5% (Jans, Stoddard, & Kraus, 2004) and 6.2% (Kessler, Berglund, Bruce, Koch, & Laska, 2001) of adults in the United States have a serious mental illness (SMI), the term applied to a group of chronic and disabling psychiatric conditions (e.g., schizophrenia, major depression, bipolar disorder) that result in functional impairment or role incapacity in one or more life domains, including vocational functioning (Goldman, Gattozzi, & Taube, 1981; World Health Organization, 2001). The disruption in vocational functioning among people with SMI is staggering. Approximately 85% of people with SMI are unemployed, and those who are working tend to be underemployed and have poor job retention (Bell & Lysaker, 1995; Mueser, Becker, & Wolfe, 2001; Twamley, Jeste,

& Lehman, 2003). Compared to other disability groups, individuals with psychiatric disabilities (or SMI) are also the least likely to have documented success in the state and federal vocational rehabilitation systems (Andrews et al., 1992; National Institute on Disability and Rehabilitation Research, 1997). This level of work impairment has enormous social costs (Cook, 2006; Marcotte & Wilcox-Gok, 2001) and reduces quality of life and satisfaction with daily activities (Arns & Linney, 1995; Eklund, Hansson, & Ahlqvist, 2004) to such an extent that Boardman, Grove, Perkins, and Shepherd (2003) asserted that "enabling people to retain or gain employment has a profound effect on more life domains than almost any other medical or social intervention" (p. 467).

In recent years, there has been growing emphasis on finding ways to assist people with SMI recover and maintain meaningful social roles, including the role of worker. "Recovery" refers to the process of psychological change that takes place in people with SMI as they grapple with the impact of mental illness and develop new meaning and purpose in their lives (Anthony, 1993; Roe & Chopra, 2003). Some authors assert that reintegrating into society and regaining instrumental role functioning, including the role of worker, is central to the process of recovery (see, e.g., Liberman, Kopelowicz, Ventura, & Gutkind, 2002; Sullivan, 1994). The term *vocational recovery* was specifically coined to capture recovery experiences in the vocational domain, or more specifically how people with SMI regain their roles as workers and reintegrate into the workforce (Russinova, Wewiorski, Lyass, Rogers, & Massaro, 2002).

A body of empirical evidence has emerged over the last two decades focusing on predictors or correlates of vocational recovery. This work has been spurred by two sets of findings: (a) from several long-term retrospective studies observing that about 70% of individuals deinstitutionalized from state psychiatric hospitals eventually returned to productive lives in the community, including employment (DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987) and (b) from research showing that employment functioning can be improved by vocational services and interventions (Bond, 2004; Cook et al., 2005; Crowther, Marshall, Bond, & Huxley, 2001; Drake, 1998; Leff et al., 2005). The predictors of vocational recovery most commonly explored to date include clinical, personal, program, and system-level variables, most of which are not easily changeable through social policy or intervention. For instance, several studies have found that better work outcomes are associated with the absence of psychosis and a diagnosis other than schizophrenia (Cook et al., 2005; McFarlane et al., 2000; Tsang, Lam, Ng, & Leung, 2000; Wewiorski & Fabian, 2004) and that persons with SMI who are male, White, younger in age, married, and more highly educated have higher rates of employment and/or longer employment tenure (Cook et al., 2005; Mueser et al., 2001; Rogers, Anthony, Cohen, & Davies, 1997; Rogers, Anthony, Lyass, & Penk, 2006; Tsang et al., 2000; Wewiorski & Fabian, 2004). Individuals with SMI who have significant cognitive impairment (Evans et al., 2004; Green, 1996; Green, Kern, Braff, & Mintz, 2000; McGurk & Mueser, 2006; McGurk, Mueser, Harvey, LaPuglia, & Marder, 2003) or co-occurring physical health or substance abuse problems (Razzano et al., 2005) also tend to have poorer outcomes. Employment success is also limited by systemic factors such as perceived stigma and discrimination in the workplace (Corrigan et al., 2003; Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Link & Phelan, 2001; Sanders Thompson, Noel, & Campbell, 2004) and work disincentives associated with the social security disability system (MacDonald-Wilson, Rogers, Ellison, & Lyass, 2003).

In an effort to more fully understand processes rather than factors linked to vocational recovery, a handful of qualitative studies have examined the work attitudes and perceptions of individuals with SMI as well as the processes or mechanisms involved in their return to work or sustained employment. Findings from these studies suggest that a combination of individual and environmental factors play a role in facilitating vocational recovery (Henry & Lucca, 2004; Honey, 2004; Killeen & O'Day, 2004; Kirsh, 2000; Krupa, 2004; Marwaha & Johnson, 2005; Provencher, Gregg, Mead, & Mueser, 2002) and that the decision to return to work or remain in a current job (Honey, 2004; Marwaha & Johnson, 2005; Provencher et al., 2002) is influenced by the perceived benefits and drawbacks of working.

However, despite the growing evidence about vocational recovery, our knowledge remains limited about the processes involved in return to work and maintenance of employment among people with SMI. The small number of qualitative studies conducted thus far include very few individuals who have progressed far enough in their recovery to be able to reflect on the factors that were helpful in their return to work. Since participants in these studies often were unemployed, not looking for work, or lacked a successful vocational history, findings from these studies tend to reflect expectations about work, rather than the actual work-related experiences of participants. For example, participants in one study expressed the desire to work and perceived many benefits associated with working, but also expressed fears, doubts, and concerns about returning to work, losing their benefits, and having their mental health needs interfere with their ability to work (Honey, 2004; Marwaha & Johnson, 2005; Provencher et al., 2002). Such individuals, who often are struggling with symptoms and experience difficulty in multiple areas of functioning, tend to be in the early stages of recovery from SMI (Spaniol, Wewiorski, Gagne, & Anthony, 2002). In contrast, individuals at later stages in their recovery, who are better able to function in multiple life domains, can better inform the field about paths to vocational recovery because they have had personal experience with employment and can share experiential knowledge about vocational success.

To learn more about the process of vocational recovery, we undertook a qualitative analysis of interviews with people at advanced stages of recovery from SMI who were participants in a study focused on their recovery process. These interviews obtained first-person information about the lived experiences of employment from individuals who had achieved vocational success. We used these interviews to identify factors and processes that facilitated return to work or sustained employment. These findings are useful for advancing theory and informing the design of programs that promote vocational recovery.

Method

Participant Recruitment

The sampling strategy of the recovery or parent study involved purposeful, criterion-based, and maximum variation sampling (Patton, 2002, 2003). We sought informants who could provide in-depth and rich information about the process of recovery from SMI, who varied on specific demographic and clinical variables (e.g., race, sex, age, psychiatric hospitalization history, co-occurring conditions, and the use of formal mental health services), and who met the following inclusion criteria: (a) the self-perception of having attained a moderate to high level of recovery and (b) possessed certain personal characteristics, such as having a range of social relationships outside the mental health community, minimal use of mental health services, and stability of psychiatric symptoms (Anthony, 1993; Deegan, 1997; Jacobson & Greenley, 2001; Liberman et al., 2002). These inclusion criteria were informed by a study of the stages of recovery from SMI (Spaniol et al., 2002) and overlap with existing definitions of recovery developed by researchers, practitioners, and people with SMI.

Participants responded to recruitment flyers, a Web site brochure, and word of mouth solicitations that sought individuals who had experienced a period of psychosis as part of a psychiatric condition and who considered their lives to be going in a positive direction for at least the past 2 years. Two researchers, who were trained clinicians and skilled in qualitative interviewing, screened respondents by phone to determine whether they met our study criteria and then interviewed selected respondents. A total of 39 respondents were screened and 24 were selected and interviewed; 1 informant was later excluded

because her interview revealed she had no history of psychosis. The final sample included 23 participants.

Participants

Participant's ages ranged from 27 to 59 years and most were in their mid to late 40s. Sixteen participants were White (9 male, 7 female) and 7 were Black (2 male, 5 female). Two participants had not completed high school, 2 had a high school diploma or General Equivalency Diploma (GED), 6 had attended some college or technical training, 9 had an undergraduate degree, and 4 had a graduate degree. Fourteen participants had never married, 3 were currently married, 5 were separated or divorced, and 1 was widowed. Although we did not formally assess psychiatric history, all participants described a psychotic episode and reported a diagnosis consistent with SMI: Sixteen participants reported a schizophrenia spectrum disorder, 5 a bipolar disorder, and 2 a disorder of major depression. Participants' longest psychiatric hospitalization ranged from a few days to more than 1 year; 6 participants had no hospitalization that exceeded 2 weeks and 5 had at least one hospitalization that lasted 4 months or longer. In addition to having a psychiatric disorder, 11 participants had a co-occurring substance abuse disorder, 2 had a trauma-related disorder, and 2 had a serious medical disorder. Seven participants reported experiencing a period of homelessness after the onset of their psychiatric disability.

At the time of the interview, 5 participants were working full-time and 13 were working part-time. The other 5 participants were unemployed but actively seeking employment. Participants were employed in a variety of jobs ranging from professional/skilled (e.g., managerial, teaching/training) to unskilled positions (e.g., clerical, janitorial). Thirteen participants had direct service experience in a mental health or other human service organization and 8 had worked in a consumer-run organization doing either direct (e.g., peer providers) or nondirect service work (e.g., administrative support staff). Additional information about respondents is available in related publications (Dunn, Wewiorski, & Rogers, 2008; Spaniol, Wewiorski, Dunn, & Chamberlin, 2005).

Data Collection

Two doctoral-level researchers/practitioners, experienced in qualitative interviewing and analysis, conducted these semi-structured in-depth interviews from February 2002 to May 2004. Interviews were audio taped, lasted approximately 90 min, and mainly occurred in the participant's home. Each participant received a cash stipend as compensation for their time. The Boston University Institutional Review Board approved all study instruments and procedures. Measures taken to protect participant confidentiality included keeping paper records and audiotapes in locked file cabinets, storing electronic information in password-protected files, and disguising participants' identities in presenting the results.

The parent recovery study (Spaniol et al., 2005) explored participants' perspectives of change over time in the following life domains: cognitive, social, vocational, psychological, emotional, physical, spiritual, cultural, and environmental. To ensure that each domain was covered during the course of the interview, an interview guide was used as a framework for conducting the interviews. The interview guide was developed by three project staff, one of whom had experienced a psychiatric disability, and was revised with a project advisory group composed of four people with psychiatric disabilities. As part of the interview, participants were asked to describe their employment history and any relationship they saw between their employment and their recovery process. For example, participants may have been asked to describe their employment during a time they were experiencing a change process or may have been asked how the change process affected their employment. Although participants provided varying amounts of information about their employment history and current work situation, each participant provided sufficient information for these analyses.

Data Analysis

The recovery study used a grounded theory approach (Charmaz, 1990; Strauss & Corbin, 1990) for its data collection and analysis strategy. Interviews were transcribed by a professional transcriptionist and subsequently checked for accuracy and completeness by the interviewer. The analysis team met biweekly to review interview transcripts and assign codes to the text in a systematic and inductive manner. Team members reviewed each transcript individually prior to a group review in which coding decisions were made about the narrative content and emerging themes. As an initial framework for analysis, codes were grouped based on the nine domains discussed above. As the coding process progressed over multiple sessions, previously developed codes were refined and new codes were created as consensus was reached. Codes were assigned to text passages using the QSR N-Vivo software. To facilitate analysis and comparison across cases, the team developed an overview summary and timeline of each person's recovery story.

The purpose of the current analysis was to develop a better understanding of the process of returning to work or maintaining employment following the onset of SMI. Our goal was to conduct a cross-case analysis (Miles & Huberman, 1994) that focused on individual-level experiences of work within the context of recovery from SMI. Thus, after the initial coding and analysis were completed, the first and third authors individually reviewed all codes and text passages related to the vocational domain and then explored the themes and larger concepts that emerged from these data. After developing an initial coding scheme for the vocational domain, these two authors re-reviewed the coded data until they reached consensus on the codes and had a tentative conceptual framework for understanding the data. To increase the trustworthiness of the findings, the second author then reviewed and helped refine the conceptual framework.

Results

In talking about their employment histories and the relationship between their work experiences and recovery, participants noted numerous factors that helped them return to work or remain employed both during and after the onset of their psychiatric condition. Our qualitative analyses of their stories

revealed seven themes that conceptually fell into two categories: individual and contextual facilitators of vocational recovery. Individual factors included feelings, attitudes, assets, and strategies such as having the confidence to work, having the motivation to work, possessing work-related skills, assessing person–job fit, and being able to create work opportunities. Contextual factors included receiving social support and having access to consumer-oriented programs and services. Although these findings are presented as discrete factors, we also show how they overlap and dynamically interact with one another.

Individual Factors

Having the confidence to work. Participants repeatedly talked about feeling confident about their ability to return to work or remain employed. This theme was exemplified by statements such as, "I felt like I could do it, so I decided I'd give it a shot." Some respondents seemed to have the confidence to work long before experiencing mental health problems and this confidence did not appear to diminish or change as a result of having a psychiatric disability. For example, a health care professional with a 20-year career prior to experiencing disabling depression noted that her confidence in her professional skills contributed to her decision to return to work early in her recovery, even though she was still actively struggling with her mental illness:

> I was like . . . driving to work a wreck, walking into the building, being, "Now I'm here, now I'm fine." . . . Getting through the day, leaving, falling apart in my car . . . [I had some reservations], but I started [working] . . . feeling, you know, well. I've always felt competent [in my profession]. I was always good at that.

Other participants did not have a consistently high level of confidence throughout their recovery, but rather their confidence grew with the passage of time or as a result of experiencing some type of vocational success. For example, one woman gained more confidence to work after she returned to work part-time following a suicide attempt and period of unemployment:

> Well, it gave me some confidence . . . working there. And then I . . . actively was seeking work, more work, and as each time something worked in . . . built self-esteem upon one success or meeting another.

In a similar way, some participants used volunteer or temporary work as a path to paid employment because it enabled them to increase their skills, which in turn increased their confidence to work. Growing confidence about the ability to work was expressed by taking on more responsibility, choosing to work more hours per week, or taking risks and making career changes that led to a new and perhaps uncertain career path.

Confidence to work seemed to come from both internal and external sources. One young woman described building her confidence to work in an office setting by wearing professional clothing that made her look and feel like a "professional woman." Several participants noted that ongoing support and encouragement from mental health professionals was instrumental in building and strengthening their confidence to work. Two participants described situations in which a therapist provided support and useful advice that bolstered their confidence to make the transition back to work. A woman who was contemplating paid employment after having a positive volunteer experience related that her therapist convinced her that she would not be a failure if the transition did not work out. That advice gave her "permission" to take the necessary steps to begin working again. Another woman described how her therapist supported her decision to pursue the goal of becoming a lawyer and helped her move past her perceived barriers to accomplishing that goal:

> And at one point I told her I have this inspiration to go to law school and she said, "I think that's wonderful. How can I help you?" So, we started working on that and you know, she helped me . . . we talked about it, there was gonna be points where I might need a reasonable accommodation, that she would support me in that . . . whether that would be more time taking the LSAT or, you know, breaks, or whatever. WHATEVER she said it was gonna take, she supported me in it . . . THAT was so significant . . . probably that was THE most significant . . . she was the first most significant person instrumental in my recovery. The reason being that I thought, you know . . . "I might have a high IQ, I might have been a straight-A student, but, I've got all these whammies, you know? I'm a recovering alcoholic, I'm a recovering drug addict, I'm bipolar, it's like I've got all this stuff on me! I'll NEVER be able to do anything, like go to law school. People like me don't get to go to law school. . . . I need to accept something less here." And she was like, "No, you can do more. You need to do more."

Having the motivation to work. Nearly all participants described having a strong motivation to work, a personal quality that pushed them to take advantage of work opportunities that arose. The desire, ability, or need to work for financial reasons fueled this motivation to find a job or continue working. To that end, participants discussed needing money to pay for housing, medical care, transportation, and other expenses so that they could become financially independent and take care of themselves. For example, a participant without health insurance decided to earn money as a laborer rather than apply for public benefits to pay for his therapy and medication. Another participant's motivation to work was spurred by her desire to gain more independence from family:

> I felt I had to go back to work, 'cause I was fortunate enough to be blessed to live with my mother, but I needed to try to fend for myself . . .

Once employed, participants often relied on their confidence and motivation for vocational success to help them remain employed. For example, a strong sense of determination was the driving force behind the sustained employment of a man who engaged in a daily fight to keep coming to work:

> . . . just the thought of going into work today makes me feel a little bit fearful and anxious. And I've been doing it for over 7 years. I don't know WHY I feel that fear and that anxiety. It's kind of a mystery to me. But I just try to work through it. I just, you know, charge right through it . . . [instead of going home] God willing, I'll go to work, I'm going to start making phone calls and doin' paperwork and that's all there is to it. Force myself to do it . . . and then the day's over . . . hallelujah!

The motivation for vocational success was also apparent when participants described career goals they hoped to accomplish in the future. For example, those who were working part-time often expressed their desire to work full-time and many specified a particular time frame for achieving this goal. Participants employed in professional positions tended to frame their motivation to succeed in terms of goals they had for their company, such as fiscal growth or expansion in new areas. Participants described not only being motivated to work but also being motivated to pursue educational, training, or other opportunities that would provide them with the skills or knowledge they needed to obtain employment in the future. These types of opportunities included taking computer classes through mental health or social service programs and participating in trainings offered by the state rehabilitation commission or other public agencies.

Work-related skills. Participants often mentioned the importance of having marketable skills, such as computer, clerical, and administrative skills, when trying to find or keep work. They acquired these skills in a variety of ways, including through early part-time positions or volunteer work. Temping, volunteering, returning to school, or participating in a vocational program helped participants develop specific skills that increased their employability and sometimes provided a direct pathway to employment. For instance, one participant with a business background acquired skills in nonprofit management while working in a part-time position that she obtained shortly after being discharged from a psychiatric hospital. She used this part-time position to develop skills that ultimately led to her being hired into a top management position in a nonprofit organization. Respondents often mentioned having the opportunity to learn new skills and reinforce existing ones while they were involved in an employment or volunteer situation:

> For instance, right now I'm learning to use a computer and the more I use it, the better I get. The more employable I become.

Acquiring new work-related skills was especially important for individuals who changed career paths and needed some specific skills to be qualified for their new career. In one instance, a participant with credentials in a medical field began taking substance abuse and addiction courses to become qualified to lead workshops for people with psychiatric disabilities because she felt "that's one area I really don't know really anything about." In another instance, a person who worked as a bookkeeper had to relearn math skills after experiencing a decline in her cognitive skills following a course of electroconvulsive therapy.

Assessing person–job fit. Prior to taking a particular paid employment position, participants often considered whether the job would be a good fit for them. They identified the type of work that would or would not be ideal for them based on their unique needs, comfort zone, and the characteristics of their psychiatric disability and then either avoided or sought out work based on their assessment of the "job fit." For example, one woman intentionally took a series of temporary jobs when she first came out of the hospital

because she knew her mental health was unstable and her inability to work consistently would put her at risk of being fired from a regular steady job. Another participant worked several different part-time positions because this arrangement allowed him to work less than 8 hr a day and maintain what he considered to be a comfortable work pace. Such decisions seemed to be very common during the early stages of recovery when psychiatric symptoms affected work stamina. Some participants chose self-employment because it allowed the flexibility to set one's own schedule and work when one felt most capable. According to one participant:

> My mental health . . . knowing there are days . . . [I needed] to shelve between prescribed hours, [I] probably wouldn't be able to do it [otherwise]. But this way, if I have a bad day, I can work double the hours the next day or work Saturday or Sunday and work it in.

This participant spent more and more of her time creating artwork for sale as she transitioned into self-employment from a high-stress job in a small company. In the following quote, she discussed how observing a coworker endure physical health problems led her to conclude that working in her current high pressure position was not right for her:

> . . . Seeing what that stress did, I just kind of said, "I don't need that." It was just kind of a wake-up call? . . . I know that art makes me feel calm and it's good and it's something that I want to do.

Creating work opportunities. Many study participants engaged in what we labeled *creating a career,* meaning that they patched together various opportunities to create full- or part-time employment. Recognizing their various talents and skills, some participants created careers through consultancy or per diem work in bookkeeping, training, and the like. Working as trainers or curriculum developers in the mental health arena was a common career path for many participants who created their own career. Participants created work opportunities that met their various needs and were not overly burdensome. For example, one person convinced a vocational rehabilitation agency to hire him to teach computer skills to people with disabilities and did this through contracts with a company he created. He then worked part-time to have the flexibility and time for other things that were important to him, such as engaging in exercise and learning new skills. Many participants created work opportunities that allowed them to have more desirable work. For example, one participant talked about "quitting my job and focusing on writing curriculum, which is what I love to do, as a way of earning money."

Participants who could self-advocate and articulate their work-related skills and capabilities sometimes created work opportunities through networking. For example, one participant expressed her interest and was hired as a trainer after participating in a workshop at a local consumer-provider program:

> So I told them several times that I'd really like to work here! And that's something I never had done in the past . . . there were like these people that I really enjoyed being around and [I] thought maybe I could do something with that. And so I started having a vision that "Maybe there IS something!"

Contextual Factors

Receiving social support. Most participants described at least one person who supported their efforts to return to work or maintain employment. Supportive relationships with employers, coworkers, family members, and mental health professionals provided them with hope, empathy, and encouragement, and led to enhanced confidence to work, increased work-related skills, and greater ability to assess their fit within a particular employment situation. Being vocal about wanting to work helped pave the way for receiving this support, which often continued even after they had found a job. One participant described a fairly typical scenario in which the advocacy of a mental health professional helped her obtain a job:

> . . . when I got ready for work, they just started advocating for me. And a position came up that I was perfect for and suggested me to the hiring manager . . . and he hired me.

Family members also provided participants with support and assistance in finding or keeping work. Those participants who worked in a family business experienced a level of support, flexibility, and other benefits that would have been hard to find elsewhere. However, these participants noted that they also needed to be ready to accept this support from family members. Some experienced family pressure to work as unhelpful even when family members were well intentioned.

Participants gave examples of mental health program staff in day programs, social clubs, and clubhouses who helped them acquire marketable skills, advocated for them in the job market, and offered them employment directly. In one example, a program helped a formerly homeless man learn computer skills and then the director offered him a job doing accounting work. This opportunity helped him develop even more sophisticated computer skills and led to his current employment in the business office of a mental health agency. Several participants described being offered work as clerical, cleaning, or kitchen staff within day programs and clubhouses. Such positions often had some flexibility and could be adjusted as the person's needs changed. For example, one participant was given more work hours when he needed more money:

> I got a 20-hour a week job. [The program director] helped me out, get started again. And I really liked that. And then I lost my disability check and she gave me 10 more hours a week in the kitchen.

As employees, participants often received ongoing support and encouragement from supervisors and coworkers that enabled them to continue to work. Their coworkers and employers were often aware of their psychiatric disability and took extra steps to be supportive. For example, a participant who was a practicing attorney described the confidence in her work ability conveyed by her coworkers during the early phase of her recovery:

> I had this first appellate case to argue. . . . And the argument, the oral argument, was scheduled a week after I got out of [psychiatric hospital], after the first suicide attempt. And I went back to the law firm and said, "I can't do this. I'm on this new medication, you know? I can't do it." And they said, "No one else CAN do it.

You're the only one that knows the case, you've worked on it, you CAN do it."

Support from supervisors was particularly apparent when participants were allowed to return to a position after the onset of their psychiatric disability or following their discharge from the hospital. In one example, a man described an employer who repeatedly rehired him after several dramatic psychotic episodes at work that involved the police and fire departments:

> I worked at a supermarket right down the street here, for 8 years. And, I would get sick and do some crazy things at work—I mean, really crazy. And they would take me back when I got better. And that's pretty remarkable, you know. I said some pretty messed up things. And they took me back two or three times.

In another example, a supervisor encouraged a dually disabled woman to enter drug rehabilitation and agreed to hold her position for her:

> But, when I came back to [state], I started all over again with the opiates. . . . I was working for this woman. She said, "Look, you're gonna die. You need to go to rehab." She was like, "I will hold your job, whatever has to be done, I will do it for you. Just get clean."

Although participants received support from a variety of sources, they also encountered individuals and employers who were unsupportive of them at various points in their life. Participants described employers who were not empathic to their struggles or who had an attitude of "pull yourself up by your bootstraps." They talked about negative relationships with coworkers who were racially prejudiced or who lacked understanding of people with psychiatric disabilities. Despite these encounters, participants seemed to be able to find people who could provide them with the support they needed. For example, one participant turned to her therapist for vocational support when her vocational rehabilitation provider was unhelpful.

Having access to consumer-oriented programs. Many participants had some direct work experience or received employment assistance through involvement with "consumer-oriented" programs, or programs that emphasize client choice, empowerment, and self-determination, recognize the importance of peers as helpers in the recovery process, and are sometimes run by people with SMI (see Henry & Lucca, 2004, for an overview). These organizations offer not only a supportive work setting but also indirect support such as pathways to employment through their extended consumer–provider networks. Being connected to a consumer-oriented program and vocalizing one's interest in working often led to work opportunities, especially positions that were not advertised formally. For instance, one participant discussed how her connection to a leader within the consumer movement led her to "create a career" within a consumer-operated agency:

> I'd just spent time at [psychiatric hospital] . . . looking for work, and someone . . . told me that [consumer leader] was looking for someone to do some bookkeeping, so . . . I went to the [self-help program]. . . . And I did their bookkeeping for a number of years. And that was a good experience for me. So I got to know a lot about what [name of consumer leader] was doing, and other people in the movement.

As organizations that valued the inclusion of persons with SMI, consumer-run programs seemed to provide an array of additional advantages that were not available elsewhere. For example, persons with SMI could easily get their "foot in the door." These were work settings in which a disability was not a liability but was viewed as an asset that could be used to develop a career. This was exemplified by participants who re-entered the workforce by using their disability to qualify for positions that specifically sought applicants with a psychiatric disability. One participant described an agency that was extremely supportive of her, even after she relapsed on drugs, because they preferred to have someone with a disability work for them:

> I do my job and I do it well and, my board does take into consideration the fact that I have an illness . . . when I first started my job, I relapsed on drugs. After a couple of months, I crashed really bad and I told my board what was going on and they supported me. . . . I went into the hospital for 3 weeks . . . they supported me on that, and then I had . . . I think a month off, after that, and they supported me, they paid me, and everything . . . because that's part of this industry, you know, is that you have to work with people who have issues like that. So they were great. I mean, they stuck by me, and now they say they're glad they did. . . . That's SO important . . . to have people there, willing to work with you.

Participants noted that consumer-oriented programs were particularly comfortable work settings because the work atmosphere and organizational culture was accepting, supportive, and nonthreatening. These organizations offered ongoing support and accommodations for a psychiatric disability could be requested without fear or resentment. For example, one person related that her coworkers in a peer-support agency accepted her absence from morning meetings due to her psychiatric condition and that this acceptance and accommodation were critical in helping her keep her job. A participant employed in a mental health program noted that "people that work there are really friendly and helpful—they go out of their way." Some participants developed meaningful relationships with their coworkers, which also helped them move forward in their recovery. A man diagnosed with schizophrenia described coworkers who supported his recovery and created a welcoming work environment in a mental health agency:

> They're wonderful . . . they knew me when I was coming out of a totally isolated state to . . . being capable to reclaim my life. And they've been really supportive. We joke around a lot, have a nice time, and work hard, but we have a good team spirit here.

Discussion

The findings of this study support existing evidence about vocational recovery, or the ability of people with SMI to return to work or remain employed following the onset of SMI. The themes that emerged from our analyses are consistent with findings that self-confidence and self-esteem, motivation, and skills (Henry & Lucca, 2004; Honey, 2004; Killeen & O'Day, 2004; Kirsh, 2000; Krupa, 2004; Marwaha & Johnson, 2005; Provencher et al., 2002) are important in helping people with SMI return to work and maintain their employment. The contextual-level factors also are consistent with previous studies that have identified the importance of supportive relationships in the process of vocational recovery (Henry & Lucca, 2004; Honey, 2004; Marwaha & Johnson, 2005). This study also identified a process that has not been noted in previous research on vocational recovery. "Creating a career" is a process through which persons with SMI adapt their work life to meet their needs rather than forcing themselves to conform to employment structures and settings that are not a good "job fit" for them. This is an example of a type of creative problem solving that is possible for persons who have self-confidence, self-knowledge, and a strong motivation to work.

Participants talked about the value of access to consumer-oriented programs and services that provided them with both direct work experiences and the opportunity to increase their work-related skills. Several previous qualitative studies have found that people with SMI acknowledge the importance of consumer-run programs generally (Henry & Lucca, 2004; Killeen & O'Day, 2004), but this emphasis has tended to be placed on training rather than as an outlet for providing direct work experiences. In addition, there are other important ways in which involvement in consumer-oriented programs may be valuable for individuals wishing to return to work. Such programs may increase a person's sense of empowerment (Rogers et al., 2007), which in turn may have a positive effect on their confidence and self-efficacy as a worker. In an empirical investigation of the active ingredients of self help and mutual support, Randall and Salem (2005) asserted that such programs can provide venues where experiential knowledge can be shared and social support is available for individuals to achieve their goals (Randall & Salem, 2005; Solomon, 2004). Thus, consumer-run programs may provide access to valuable role models in individuals who have returned to work (or are working within the program) as well as the instrumental resources and social supports to facilitate higher levels of vocational functioning among its members.

We found considerable overlap between and among the individual- and contextual-level domains, a finding that was not surprising given existing social and ecological models (Bronfenbrenner, 1977; Stokols, 1996; Stokols, Allen, & Bellingham, 1996) that emphasize how behavior and health-related outcomes are the result of interactions between individual, interpersonal, institutional, community, and policy factors. For example, similar to Kirsh (2000), we found that relationships with supervisors and coworkers affected participants' work quality of life, self-esteem, and, for some, the ability to maintain a position. The support received in relation to work was reflective of the social support received within other life domains and this social support appeared to facilitate the overall process of recovery from SMI (Spaniol et al., 2005). The fact that most of these factors overlapped with one another suggests that a combination of factors, working simultaneously and interactively over time, may be important in facilitating return to work and sustained employment among people with SMI. For example, once people have the confidence to return to work, they seem to find others within their social network who support them in accomplishing their vocational goals. If they fail to find this support initially, they seek out other individuals in their life who provide them with the support they need. In this way, individual factors are strengthened by contextual factors available in the person's environment. In addition, the considerable overlap across

factors suggests that a combination of elements may be necessary to achieve vocational success and that no single factor alone is potent enough to determine the ability to return to work or maintain employment. It may be that some combination of individual and contextual factors is necessary for vocational success. For example, high motivation and support from others may be necessary but insufficient for vocational success without also having the required skills or confidence to work in a particular job. This appeared to be the case for many of our participants.

The findings from this study are in sharp contrast with the numerous studies that have focused on people with SMI who are unemployed or underemployed and that report on their feelings of pessimism about finding or keeping a job, and their experiences with the host of barriers that prevent them from being able to return to work (Henry & Lucca, 2004; Marwaha & Johnson, 2005). Although participants in this study did talk about the barriers they encountered at various points in their lives, such as receiving negative messages from providers or family members about their ability to return to work, these individuals tended to focus on the facilitators of employment success. This tendency may have been an artifact of the goals of the study (to identify what helped participants reach a moderate or advanced level of recovery), leaving people to feel less inclined to talk about factors that were unhelpful. However, it also may reflect the extent to which individuals who attain a moderate to advanced stage of recovery from SMI are able to overcome whatever barriers they encounter.

Limitations

Since this study included only individuals who reported and who we assessed to be at a moderately advanced level of recovery, our findings should not be generalized to the broader population of people with SMI. People at this stage of their recovery may have different motivations for work and view their role as a worker differently from individuals at lower levels of recovery. For instance, individuals at lower levels of recovery may be preoccupied with issues related to their illness and may view even their past work experiences with a different perspective. However, in view of the fact that many consumers, researchers, and practitioners consider recovery to exist along a continuum with discrete stages (Spaniol et al., 2002), it is likely that the findings from this study reflect experiences and processes that are common among people at advanced stages on this recovery continuum. Furthermore, the purpose of the parent study was broad in scope and was not specifically designed to uncover factors related to vocational recovery. Although every participant did talk about employment extensively, we may have failed to explore other important paths of exploration or queries specifically related to employment as part of our data collection process. However, having input from consumers of mental health services in the development and analysis of the data (for the parent study) may help partially address this limitation.

Theoretical and Practical Implications

This study identifies seven individual and environmental factors that appear to be associated with vocational success for people who are able to attain moderate to advanced levels of recovery from SMI. Unlike demographic characteristics, work history, and other fixed attributes described in numerous studies of vocational outcomes for this population, the factors identified in this study are malleable and can be open to change through the use of targeted employment-related services and policies. These findings need to be investigated further in an effort to advance our theoretical understanding of recovery and determine if there are specific learnings that can be translated into practice guidelines and policies to promote the employment and sustained employment of persons with SMI.

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