The Role of Work in the Recovery of Persons with Psychiatric Disabilities

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This study explored the role of work in the recovery of employed and unemployed persons with psychiatric disabilities. Fourteen persons with psychiatric disabilities participated in semi-structured interviews. Content analysis revealed that the experience of recovery was based on six major dimensions: self-definition, empowerment, connections to others, meaning of work, vocational future, and meaning of recovery. Differences in these six dimensions led to the identification of three profiles of recovery: recovery as uncertain, recovery as a self-empowering experience, and recovery as a challenging experience. Each profile described a specific context in which participation in work or avoidance of work can be understood and vocational interventions can be designed.

The majority of unemployed persons with psychiatric disabilities desire work (Rogers, Anthony, Toole, & Brown, 1991). However, long-term unemployment remains a major problem for this population. Rates of competitive employment range between 10-20% (Anthony & Blanch, 1987; Brekke, Levin, Wolkon, Sobel, & Slade, 1993; Rogers, Anthony, & Jansen, 1988). Supported employment for persons with psychiatric disabilities (Becker & Drake, 1994) has provided renewed optimism for attaining competitive jobs (Drake, McHugo, Becker, Anthony, & Clark, 1996; Drake, et al., 1999). Nevertheless, dropout rates remain high in some supported employment programs, in excess of 40% (Bond, Dietzen, McGrew, & Miller, 1995; Shafer & Huang, 1995). Job tenure is also problematic, considering that 70 days is the average job tenure in a supported employment program (Xie, Dain, Becker, & Drake, 1997).

A major unresolved question in the field of vocational rehabilitation is whether the benefits of work generalize to non-vocational domains, such as symptoms, self-esteem, depression, quality of life, treatment cooperation, clinical and social stability. The benefits of supported employment appear limited to vocational outcomes, with minimal crossover effects in other life domains (Mueser, Drake, & Bond, 1997b). In addition, there are conflicting findings about the relationships between work status and measures of functioning in vocational domains, such as self-esteem (Arns & Linney, 1993;

Bailey, Ricketts, Becker, Xie, & Drake, 1998; Chandler, Meisel, Hu, McGowen, & Madison, 1997; Mueser et al., 1997a; Torrey, Mueser, McHugo, & Drake, 2000; Van Dongen, 1996), and overall satisfaction with life (Arns & Linney, 1993; Fabian, 1989; Lehman, 1988; Mueser et al., 1997a).

Another important question concerns the relationship between the subjective experience of work and functioning in non-vocational domains. For instance, employed individuals may experience increased self-esteem as long as their jobs offer them opportunities to empower themselves. In vocational research, work has been mainly studied through the use of objective measures, such as employment status (e.g., working versus non-working), number of hours worked, earned wages, or job tenure. Little is known about the perspectives of persons with psychiatric disabilities on their work experiences and how they view the influence of work on other areas of their lives (Honey, 2000).

The field of recovery is a promising area for exploring the subjective experience of work in the lives of persons with psychiatric disabilities. Based on first-person accounts and writings in the field of psychiatric rehabilitation (Anthony, 1993, 2000; Deegan, 1988; Spaniol, Koehler, & Hutchinson, 1994), recovery is defined as the process of transcending symptoms, psychiatric disabilities and social handicaps. It involves the re-definition of a sense of self, the emergence of hope, the development of self and collective empowerment, and the establishment of meaningful relationships with others. Recovery is oriented towards the reconstruction of meaning and purpose in one's life, the performance of significant social roles, the experience of wellness, and satisfaction with life.

Qualitative findings are emerging on the subjective experience of work in recovery. Social factors that have a positive influence on job search and job retention include the development of a sense of belonging through participation in social activities, the use of professional help for maintaining mental and physical functioning, and the willingness to play an active role in maintaining meaningful relationships with others, including friends, family members, and mental health providers (Alverson, Alverson, Drake, & Becker, 1998). The possibility of finding a job that matches one's preferences, strengths, and goals (Smith, 2000) and the desire to be more active (Young & Ensing, 1999) are two other important factors in individuals returning to work. Among employed individuals, work is perceived as a means of coping with psychiatric disabilities and a way of developing a sense of self-empowerment (Alverson, Becker, & Drake, 1995; Strong, 1998; Young & Ensing, 1999). Work also helps individuals develop a positive outlook on themselves, reinforces their belief in a better future, and increases their willingness to expose themselves to new learning experiences (Alverson et al., 1995; Young & Ensing, 1999). Along with the recovery process, work is often appraised as a meaningful opportunity for pursuing further self-development, making additional improvements in quality of life, and enhancing the experience of wellness (Strong, 1998; Young & Ensing, 1999). Overall, these findings provide some initial support for the role of work as a vehicle of self-transformation in recovery.

However, little is known about the role of work in recovery from the perspectives of unemployed persons with psychiatric disabilities. Although Strong (1998) explored the meaning of work in recovery, her sample only included working individuals. This is an important gap in the literature as unemployed individuals represent a large and diverse group in terms of their efforts to pursue employment. Furthermore, unemployed persons may differ in their motivation for work, which may influence their chances of obtaining employment. For example, among unemployed individuals with schizophrenia, a recent study (Mueser, Salyers, & Mueser, 2001) found that those who wanted to work and had made efforts to find work in the past month were three times more likely to be working one year and two years later than those not interested in work.

The purpose of this study was to explore the role of work in the recovery of employed and unemployed persons with psychiatric disabilities. Such exploration may contribute to developing a better understanding of the recovery dimensions that shape the experience of work, and the value of work in molding the recovery journey. For clinicians, this research may also provide suggestions for tailoring supported employment services to persons with psychiatric disabilities based on their own pattern of recovery and the meaning of work to them.

METHOD

Participants

Qualitative data were collected through individual interviews. Potential participants were referred by mental health providers at two local Community Mental Health Centers (CMHC) and the directors of two peer support centers, all located in New Hampshire. Fifteen persons with psychiatric disabilities were invited to participate in the study. One person declined to participate. The final sample was constituted of 14 participants, eight from peer support centers and six from CMHCs.

Table 1 summarizes the characteristics of the participants. For four variables, the duration of illness, the number of hospitalizations, the earned wages and the number of hours worked, the median

are here reported rather the mean, because of the wide range of values and the small sample size. Among the six employed participants, a variety of types of jobs were held, with three working entry-level jobs, two with skilled jobs, and one working as a peer helper in a community resource center run by persons with psychiatric disabilities. Among the eight participants who were not employed, four had worked as peer helpers in the past five years. For the whole sample, participants had held an average of 1.4 competitive jobs over the past five years.

Measure

A semi-structured interview was developed to explore the experience of recovery. It included a series of seven primary questions tapping the major dimensions of recovery: basic life responsibilities, hope, coping with emotional problems, self-efficacy, sense of identity, and personal significance of work. Follow-up questions were asked after each primary question to explore the unique aspects of each person's recovery experience. They were directed towards the strengths of the participants, their past and present successes, and their current and future challenges. The original interview was based on a survey of the literature and reviewed by four experts in the field of recovery and vocational rehabilitation, including a person with psychiatric disabilities. The interview was piloted with three persons with psychiatric disabilities.

Following informed consent, individuals participated in the interview, which lasted 90 minutes on average. Thirteen interviews were audiotaped and transcribed verbatim. Notes were written down immediately after the termination of one interview. Thirteen interviews were conducted at peer support centers or CMHCs, and one at the participant's home. Individuals were paid $20 for their participation in the study.

Table 1—Participant Characteristics (*N* = 14)

Characteristics	*N*	%
Demographic variables		
Gender		
Men	8	57.1
Women	6	42.9
Mean ± SD age (years)[1]	44 ± 8.3	
Marital status		
Single	6	42.9
Married	4	28.6
Separated	1	7.1
Divorced	3	21.4
Education		
Less than high school	2	14.3
High school	1	7.1
Some college	4	28.6
College degree	7	50
Living Arrangements		
Independent living	9	64.3
Living with parents	5	35.7
Clinical variables		
Psychiatric diagnosis		
Schizophrenia	6	42.8
Schizoaffective disorder	2	14.3
Bipolar disorders	2	14.3
Depression	2	14.3
Posttraumatic stress disorder	2	14.3
Median duration of illness (years)[2]	14	
Median number of psychiatric hospitalizations[3]	11	
Work variables		
Work status		
Working	6	42.9
Searching for work	4	28.6
Not interested in work	4	28.6
Participation in supported employment		
Yes	3	21.4
No	11	78.6
Median job tenure (weeks)[4]	78	
Median hourly wage[5]	$8	
Median number of hours per week[6]	15	

Notes
[1] Range: 29 to 58 years
[2] Range: 4 to 40 years
[3] Range: 2 to 55 hospitalizations
[4] Range: 26 to 260 weeks
[5] Range: 5 to 23 dollars
[6] Range: 7 to 50

Table 2—The Experience of Recovery in Persons with Psychiatric Disabilities: Three Profiles

	Vocational Status	Self-Definition	Empowerment	Connections to Others	Meaning of Work	Vocational Future	Meaning of Recovery
Profile I—Recovery is uncertain (*N* = 4)	1W 2S 1NIW	Vulnerable sense of self	Low sense of empowerment	Limited	Means of passing time	Unclear	Uncertainty
Profile II—Recovery is a self-experience (*N* = 8)	3W 2S 3NIW	Expanding sense of self	Building a sense of empowerment	Moderate	Means of self-empowerment	Positive outlook	Self-reconstruction process
Profile III—Recovery is a challenging experience (*N* = 2)	2W	Multi-dimensional sense of self	Empowered	Strong	Means of self-actualization	Promising	Challenging process

Note. (W) for Working; (S) for Searching for work; (NIW) for Not Interested in Work

Analysis

A content analysis and a constant, reiterative comparative method (Miles & Huberman, 1994) were used to analyze the data with the assistance of NUD*IST 4 (Non-numerical, Unstructured, Data-Indexing, Searching Theorizing; Sage Publications Software, 1997). A four-step method was used to analyze the data. First, each interview was broken down into individual meaning units. Second, similar individual meaning units were regrouped under a unifying theme. Third, underlying characteristics were identified for each theme. Finally, a summary table was built to compare themes and their related characteristics within and across participants, which led to the identification of distinct profiles characterizing the experience of recovery.

The first five transcripts were coded independently into meaning units by the three interviewers (RG, SM, and HP), and a consensus was reached before attempting to further analyze the data. Four other interviews were independently coded by SM and HP, and the five remaining interviews by the first author. Regarding the two last steps of the analysis, a consensus was reached between RG, SM, and HP at each level.

Results

Six themes framed the experience of recovery: self-definition, empowerment, connection to others, meaning of work, vocational future, and meaning of recovery. Based on these themes and their underlying characteristics, three profiles of recovery were identified. Although overlap in profiles appears possible, it was not observed in this sample. Table 2 provides a summary of each profile.

Profile I: Recovery as Uncertain

Four participants belonged to Profile I. One participant was employed as a janitor and the three others were unemployed. Among these three participants, two searched for work, and another one was not interested in work.

Self-definition. A sense of personal vulnerability characterized these participants. On a functional level, they were overwhelmed by the presence of emotional problems in their lives. They reported difficulties in managing unstable symptoms, such as transient hallucinations or delusions, as well as mood swings, and stress, which led to disruptions in their daily living. For instance, one participant reported,

> Sometimes I get so stressed out that I just stop functioning. I usually just curl up and go to bed and stay in bed all day. That's usually how I deal with it. Other times I get depressed and talk negatively and aggravate everybody around me.

They also had difficulties in maintaining regular health habits, such as eating balanced meals and sleeping enough. Commenting on his sleeping habits, one participant stated,

> Right now I'm tired because I went to bed at 4:30 and I woke up at 9:30 and I'm on a screwy sleep pattern. Now it is a psychological thing. All those years of being depressed, I couldn't read. Now I stay up all

> night reading. I have screwed up my whole schedule and have to get back on a normal sleep schedule.

Subjectively, participants found their days were unpredictable, with some better than others. As a result, participants took one day at a time, and were reluctant to plan ahead.

On an experiential level, participants had a poor sense of self-esteem and serious doubts about their abilities to make significant changes in their lives. For example, the search for work brought these thoughts and feelings in one participant:

> I'm scared. I used to be a cocky 18-year-old kid who could move mountains, and I don't know if I could even move a pebble now… I still have self-esteem problems, fears, doubts, and insecurities. I have this stigma hanging over my head now. You look at the employment forms and you have to throw out reason for leaving. What do you say? You can't say I have a mental illness. Stuff like that. There is such a stigma out there right now about this kind of stuff.

In short, the overwhelming experience of dealing with psychiatric disabilities, the unpredictability of emotional problems, the difficulties in coping with stigma, and the building of a self-image based on the perceived limitations of their illness have contributed to the development of a sense of personal vulnerability in these participants.

Empowerment. Participants belonging to Profile I experienced a low sense of empowerment. This was expressed in their ways of coping with emotional problems and stress, which were marked by the use of passive and avoidant strategies, and the heavy reliance on external resources. For example, one participant quit his most recent job because of the effect of job pressures on his work performance. He stated,

> There were a lot of demands on me, especially when I was working a full-time job. It just broke me. I felt like I had hit a wall and couldn't function at all, and I would just walk off the job. It wasn't a matter of choice; it was just something I couldn't handle any more.

This negative work experience was an important factor in the participant's decision to stop work and to devote his time to housekeeping activities. Participants believed that they had little control over their emotional problems. One participant expressed a total lack of control, stating,

> My mind is victim of those powers, telepathic powers…there is nothing I can do. My mind just takes off.

Participants also relied predominantly on external resources to cope with their emotional problems, such as taking medication and seeking help from mental health professionals. The use of these strategies reflects the participants' limited beliefs in their abilities to develop self-control strategies.

Finally, the low sense of empowerment in participants with this profile was reinforced by their daily efforts towards the maintenance of a secure environment, in which self-protection was assured but self-development prevented. Participants preferred to maintain the "status quo" rather than to strive to make significant changes in their lives. The fact that they were satisfied with their overall quality of life, including living arrangement, finances, and leisure activities, was a disincentive to any change. Although they considered that their material conditions could be further improved, they were not in a hurry to do so. The self-protective environment also represented a refuge from social discrimination against people with psychiatric disabilities. For example, one participant had experienced discrimination in previous jobs, which combined with his perceived difficulties to cope with stress at work, led him to stop work. He needed time to heal the emotional scars left by these experiences, including angry feelings and a poor sense of self-esteem. He stated,

> I haven't bridged the gap between myself and other people because of the way I have been treated in the past. I have been discriminated against and my rights have been trodden on at different places I have worked because of my illness and others not understanding it.

Connections to others. Three of the four participants reported superficial contacts with family members and friends. Participants provided some explanations for their difficulties in building close relationships with others. One participant viewed self-disclosure as an act of "complaining" about himself, which made him reluctant to share thoughts and feelings with others. Another participant had experienced significant losses since the onset of his emotional problems, including the breaking off of his relationships with his wife and children. He stated,

> I lost everything I had. I lost the house, I lost my wife, I haven't seen my kids in seven years, I lost my job, and I lost myself.

Although he wanted to reconnect with his daughters in the future, he preferred to avoid contact with them for the moment. He expressed this viewpoint by stating,

> I'm no good for them. I'm not healthy and not there for them. I have my good days and my bad days.

These findings suggest that limiting social contact was a strategy that participants used to protect their vulnerable sense of self.

Finally, spiritual connections were important for two participants. One partic-

ipant perceived his relationships with God as very supportive. He stated,

> He helps me to keep going. If I didn't have God and I went through what I went through, I know that I would not be alive right now. It is my faith that keeps me from hurting myself because I do have thoughts about hurting myself.

This participant also appreciated the possibility of sharing his spiritual experience with his wife. For the other participant, relying on spiritual support compensated for his lack of motivation to seek emotional support from others.

Meaning of work. Work was perceived as a means of "passing time" in participants belonging to Profile I. As one participant who searched for work put it,

> Time would fly by more quickly if I were working.

Apart from keeping busy, work was not viewed as an activity that contributed to self-development, as participants had little confidence in their own potential and minimal hope about building new strengths. For instance, one participant who disliked his job as a janitor had kept working in that position for seven years because he thought that it was his "duty."

Vocational future. Three out of four participants with this profile viewed their vocational future as unclear. This included the two participants who searched for work and another participant who was not interested in work. The three participants were hesitant to project themselves into the future and had doubts about their abilities to achieve personal goals.

In line with their vulnerable sense of self, they tended to report internal barriers to employment, such as difficulties with concentration, lack of confidence in vocational abilities, and fear of resuming work after years of unemployment. For example, taking charge of the housekeeping chores was a sound alternative to employment for one participant. He perceived it as a means of keeping himself busy, helping out his wife, and dealing with uncertainties about his future work. He stated,

> After talking with my wife, we decided that I would be better off staying home permanently and taking care of the affairs of the home rather than trying to take on another job and not knowing whether or not I would be able to handle it down the road.

Fear of losing benefits was another major barrier for three participants. Two participants who searched for work relied on their vocational counselor to help them to cope with these barriers. The other participant wanted to manage his emotional problems more effectively before getting help to find a job.

Meaning of recovery. As shown in Table 2, participants with this profile were uncertain about the possibility of recovering from mental illness. For example, one participant viewed his recovery as dependent upon the discovery of new medication that would help him to regain full self-confidence. As he put it,

> I don't have too much hope for recovery unless they come out with a medication that helps me get more confident. I'm not confident about recovery.

Another participant applied the AA philosophy of taking one step at a time to cope with his emotional problems. He stated,

> I take a lot of the principles they taught me in AA and apply them to the depression. I take one day at a time. Yesterday is history, tomorrow is a mystery; yesterday is a canceled check, and tomorrow is a promissory note. All we do is have today. All we do is have this moment right here. For all general purposes, I might have a heart attack and be dead on the floor and that would be the end of the tape. But that's all we have is this minute.

As exemplified by these quotes, an external locus of control and an over-emphasis on the present prevented participants from believing in their abilities to make significant changes in their lives.

Profile II: Recovery as a Self-Empowering Experience

Eight participants belonged to Profile II. Their vocational status varied. Three participants worked on a part-time basis, two held entry-level jobs, and one worked as a peer helper. Two participants in this profile were searching for work, and three were not interested in work.

Self-definition. Participants were in the process of expanding their sense of self. This implied the re-definition of a more active sense of self. Participants wanted to exert more personal control over their lives by regaining former parts of the self. Setting goals helped them to target aspects of the self to be empowered. These goals were oriented towards: (a) the effective management of emotional problems; (b) the achievement of greater independence in the areas of work, housing (e.g., "moving out from parents"), or finances (e.g., buying car); (c) the improvement of social relationships (e.g., "to enlarge one's circle of friends"); and (d) the development of healthier habits (e.g., getting exercise, losing weight, quitting smoking). Although these goals were attached to different life domains, having sufficient personal control over emotional problems was a crucial step in moving ahead in their recovery. It instilled hope for the pursuit of other goals. As one participant put it,

> My illness is under my control. The illness seems to get better. Maybe I will be able to drive again.

Empowerment. As shown in Table 2, participants within this profile were involved in the task of building a sense of empowerment. Two outcomes revealed the emergence of self-empowerment. First, participants developed strategies to have better control over their emotional problems. Second, they started to build their self-efficacy through participation in work.

Strategies to control emotional problems. Participants used a variety of behavioral and cognitive strategies to feel empowered in their struggles with emotional problems. On a behavioral level, participants employed two major types of strategies, those for preventing relapses and those for coping with stress. To prevent relapses, participants relied on the recognition of warning signs, the use of medication, and for some participants, the preparation of a crisis plan. To cope with stress, participants used strategies to decrease stress, such as having a daily routine, writing a daily journal, taking a nap, or going out. Commenting on the helpfulness of writing her journal on a daily basis, one participant stated,

> It helps to get racing thoughts out of my head and on paper. Once I get it written down, I can stop ruminating about stuff.

On a cognitive level, participants used positive self-appraisal, reappraisal of emotional problems, and self-discovery strategies. Positive self-appraisal corresponded to thinking about oneself in a positive light and believing in one's potential. This was perceived as a crucial step in the process of self-empowerment. As one participant put it,

> The biggest thing is for me to feel positive about myself. Believing in myself is a big step right there.

Reappraisal of emotional problems involved the search for explanations to the question "why me?" representing a strategy for moving away from self-blame. Disrupted family relationships, brain chemistry dysfunction, and trauma in childhood were some explanations for the illness offered by participants. Finally, self-discovery strategies were used to target aspects of the self that could be further empowered. They were oriented towards the identification of personal preferences, strengths, and limitations. Psychotherapy and self-help material (e.g., motivational tapes, books) were perceived as valuable self-discovery strategies. For example, reflecting on his experience in psychotherapy, one participant stated,

> There is a psychotherapist that I see. I feel really comfortable with him. The more we talk, the more things come out, and the more I can find what I really want.

Sense of self-efficacy. All but one participant belonging to Profile II had held part-time jobs in the past five years. Among the seven participants, three had worked as peer helpers, three had held entry-level jobs, and one worked as teaching assistant. All of these participants reported a sense of self-efficacy and pride in their work. They had proved to themselves and others that they were able to work. Two unique advantages of work emerged from the peer helper job. As peer helpers, participants experienced for the first time a sense of usefulness to others, which helped them to develop positive feelings about themselves. As one participant put it,

> Peer support work was a very big boost to my ego.

Peer helper jobs also enabled participants to learn how to better use their personal strengths in connecting with others. In this vein, one participant stated,

> I am getting better at hanging out with all kinds of people and finding something to say because part of my job is to talk with people when they come to the center.

Connections to others. One subset of four participants relied primarily on family members for social support. Among them, two participants were married. Their partners were the most significant persons in their lives. For example, one participant mentioned that his wife brought him "love, companionship, peacefulness." He also stressed the support that he got from her in building more confidence in himself. The two other participants of the four lived with their parents. Their mothers played a central role in their recovery. They offered emotional support and guidance in the management of their emotional problems, which involved remaining abstinent from drugs or preventing relapses.

Another subset of four participants relied primarily on mental health providers or peers for emotional support and advice in coping with their emotional problems. Participants preferred to confide in them instead of family members because they did not want to worry family members or close friends about their problems. For example, commenting on the relationships with her mother and siblings, one participant stated,

> I don't tell them that I'm suicidal or something like that. I talk to counselors or somebody else because I don't want to scare my family.

Regarding peer support, three participants emphasized the sense of empowerment that emerged from their relationships with peers. As one participant put it,

> It brings companionship and a feeling of equality and respect. I am treated as an equal and as a competent person. That helps me to feel better about myself, and less depressed.

Three other features characterized the social interactions of participants belonging to Profile II, independent of the structure of their social networks. First, the majority of participants reported having input into their mental health treatment. In particular, two participants had been successful in advocating for a change in therapist or rehabilitation approach. Second, half of the eight participants sought support and meaning for their ongoing struggle with emotional problems from spiritual sources. For instance, one participant stated,

> God won't give you more than you can handle. He won't push you beyond your limit.

Finally, most participants felt accepted and understood by significant others, which helped them to cope with stigma and to move forward in their efforts toward recovery.

In conclusion, all but two persons with this profile were satisfied with their connections with others. However, most had limited experience in establishing reciprocal relationships, which were only present in the two married individuals. Hope characterized these participants who wanted to improve their ways of connecting with others.

Meaning of work. As illustrated in Table 2, work represented a means of self-empowerment for participants with this profile. It was intrinsically tied to their experience of recovery in four major ways. First, work was a way of building self-efficacy in participants, which has been previously discussed along with the theme of self-empowerment. Second, work was a way of coping with emotional problems. It represented a source of motivation, especially for those participants struggling with apathy and depression. For example, work helped one participant start her day and get out of the house. For another participant, work allowed her to interact with people during the daytime instead of isolating. For two participants, work provided opportunities to improve their social skills, as they wanted to work or worked in a setting that exposed them to more contacts with others. Third, work was a means of obtaining more money. Most of the participants in this profile wanted to earn more money for reasons such as buying a car, taking vacation, shopping, eating in restaurants, or to save money for future plans. Finally, work was a source of enjoyment. Participants liked their jobs and/or were seeking rewarding work experiences. For those employed participants, work contributed to making them feel good about themselves, which was perceived as a major source of motivation. The good fit between work characteristics and personal preferences and goals was critical for experiencing such a rewarding experience. For example, one participant commented on his previous vocational experience in a peer support center in these terms,

> I like working in a program like this because it makes me feel like I'm doing something not just for me but for other people, and to me that's important. Earning money isn't so important in its own right. It helps me feel good about myself, and I know that I'm contributing to help other people.

For this participant, working at the peer support represented a source of satisfaction and meaning, as it allowed him to pursue his personal interests by providing assistance and help to people.

Vocational future. Participants belonging to Profile II had a positive outlook on their future work. Participants had two types of vocational goals. Five participants wanted to continue in their current jobs or go back to former ones. The other two participants who worked wanted to keep their jobs, although one wanted to work additional hours. The two participants who were searching for work wanted to work in areas consistent with their previous vocational backgrounds. Finally, one participant wanted to continue his writing activities. All five participants were satisfied with their current or recent jobs, which partly explained their motivation to pursue these types of vocational activities.

In contrast, another subset of three participants wanted to make a change in their careers. Among them, one participant worked as a peer helper. The two other participants were not interested in work on a short-term basis but wanted to resume work eventually. All three participants had worked as peer helpers in the past five years, which helped them to explore their personal interests, to identify new strengths, and to envision new challenges. Work possibilities within the helping professions became an area of interest for two participants, while the computer field was attractive to the other participant.

Participants identified internal and external barriers to achieve their vocational goals. Regarding internal barriers, unpredictable sleeping patterns and fear of failure prevented two participants from working, while the fear of relapse was an important concern for one participant who nevertheless was searching for work. Instability of one's own motivation to work was another type of internal barrier, as reported by an employed participant. Keeping his motivation afloat was an "inner struggle" for him.

Regarding external barriers, losing disability benefits was an important disincentive to work for two participants. One of them viewed volunteer work as an interesting option that allowed her to resume working while keeping her benefits. The anticipated loss of benefits was also a major barrier for one participant who wanted to work more hours. Another external barrier was the fear of social discrimination, which was expressed by one participant who worked

as a peer helper. Apart from this job, she had been out of work for four years. She was concerned about how the gap in her résumé would be interpreted by future employers. She used anticipatory coping strategies to deal with this concern, such as picturing herself in job interviews and focusing on her strengths and not disclosing her history of emotional problems. Another participant who was working at the time of the interview had experienced social discrimination in previous attempts to find a job. He remembered vividly feeling like an outcast and still experienced anger and a sense of helplessness about it.

Meaning of recovery. Recovery was a process of self-reconstruction for persons with this profile (see Table 2). It was perceived as a way of regaining aspects of the self that have been lost, discovering new personal strengths, and developing a positive attitude towards oneself.

Recapturing aspects of the self included an examination of former roles and activities. For example, one participant who lost custody of her children wanted to resume her parental role by regaining custody of her daughters. Another participant wanted to resume her artistic activities. She stated,

> I used to do writing and painting but I haven't been able to do that for a couple of years because of the depression and lack of desire to do it. I actually haven't painted in about ten years. I haven't written anything in about two years. Recovery for me would be getting my creative energy back and doing some painting or writing. Recovery would be feeling more confident than I do right now and being more active.

Regaining independence was another way of getting back lost aspects of the self. For example, one participant defined recovery in the following terms:

> Taking steps and trying to get back into a normal everyday life. I'd like to have a little private garden, do shopping on my own, pay all my own bills.

Other participants expressed their views about regaining former aspects of themselves in a more general way. They stressed the importance of having more stability in their lives, and reducing the effects of enduring symptoms and relapses.

For some participants, the discovery of new strengths was also part of the self-reconstruction task. The motivation to learn was perceived as a significant asset in building new abilities or aspects of the self. In this vein, one participant stated,

> Recovery is learning more skills, getting better at what you don't know how to do. Like I didn't used to talk. I didn't know how. I was silent, but therapy has taught me to talk.

Finally, for other participants, recovery simply meant "feeling good about myself" or "having a better outlook on myself." Developing a positive view about oneself was of utmost importance for these participants. They attached more value to their personal feelings toward themselves in recovering than to the performance of roles.

Profile III: Recovery as a Challenge

Only two participants belonged to Profile III. Both were employed, one as an administrator in a peer support center and the other as a mental health consultant. Their striking differences from the rest of the individuals in our sample in self-definition, empowerment, and meanings of work and recovery led us to distinguish them from other participants.

Self-definition. The two participants with this profile assumed several role functions, such as worker, parent, and partner. They defined themselves in terms of these multiple roles. They had been successful in developing an active sense of self, apart from their psychiatric illness. In addition, they had learned strategies that helped them to deal effectively with their emotional problems. As a result, they spent less time and energy in coping with them, and more in participating in activities further enhancing their sense of self. The presence of emotional problems was integrated in their everyday lives. For example, one participant stated,

> I don't call my problems "emotional" anymore. I call them "everyday life stressors."

Moving beyond disabilities was a hard and long journey for both participants. The rediscovery and reconstruction of an active sense of self was perceived as a healing process, which involved connecting with former aspects of self and building on them. As one participant stated, "who I am today is because of my past."

Their active sense of self was also reinforced by their tendency to appraise stressful events as "challenges." They were hopeful about their ability to not only deal with difficult situations, but to learn from them and to further empower their sense of self. The following quote from one participant illustrates the importance of putting the self into action through involvement in challenging situations:

> Learning everything that I've learned on computer has been a challenge, but I enjoy that challenge. My goodness, some days even driving in traffic is a challenge. So instead of being a perfectionist and setting the standards too high, which I have been known to do for myself, I set smaller goals that I have to reach for and work for. For example, learning the typing program has been a challenge for me. I allow myself the time to sit down and practice a little. Then I try to type about

> 40 words per minute, and then for 42 words per minute. Because for me, that type of challenge builds my self-confidence.

In short, learning from past and present experiences, valuing changes, and appraising problematic events as challenges were all factors that contributed to the development of a multidimensional concept of self in the two participants.

Empowerment. The two participants belonging to Profile III felt empowered. Four outcomes of empowerment were revealed from these participants' stories: knowledge of self and the environment, beliefs about self-control, self-efficacy, and use of proactive strategies.

Knowledge of self and the environment. Both participants were well aware of their personal strengths and knew how and when to use them at their best. They also paid attention to the presence of environmental forces potentially contributing to or interfering with their personal goals. The use of this combined knowledge of self (e.g., personal assets and limitations) and the environment (e.g., facilitators and barriers) was critical to their perceived chances of success in pursuing their goals. For example, one participant discussed her way of assessing situations as follows:

> I've learned to distinguish what is in my control and what I can do about it. I just have to look at the situation realistically: what can I do to have control of the situation? It's like going through a checklist. The pros and cons. And then there are those things that are not under my control and I have to decide how I'm going to deal with them. Am I going to let them go? That's the hardest part, learning to let things go that I have no control over.

Beliefs of control. Both participants firmly believed that they had control over their lives. For example, one participant stated,

> I wake up every morning and the first thing on my mind is a brand new day and I can make it anything I want. I have that power, I can control where I am going to go and what I am going to do with my life…does not mean that I am not scared, but I do have the courage to face every day.

Self-efficacy. These two participants felt good and satisfied with their work and in other domains of their lives, such as parenting and intimate relationships. Regarding their work, both participants had been employed on a full-time basis for the past five years. Finally, they were motivated to constantly improve their abilities and to learn more about themselves through pursuing their vocational and other activities.

Proactive strategies. Setting realistic goals, monitoring stress levels, and using problem-solving skills were proactive strategies used by the two participants. In addition, participants used a "letting go" strategy for things that were not under their personal control. For example, one participant emphasized the importance of this latter strategy as follows:

> If I find that there are some things I have no control over, especially another person's reaction, I just let it go, don't obsess about it, don't try to fix it for them, just have to let it go. Even with my husband and my child there are just things I have to let go.

Connections to others. Relationships with friends and immediate family members were important sources of support for the two participants. For one participant, the turning point in her recovery was the support she got from a friend, whom she considered a mentor. This friend believed in her potential and lent her money to buy a car, allowing her to start a new job after having been unemployed for several years.

Both participants benefited from strong support from others and were satisfied with their relationships with others. Parental relationships were perceived as growth opportunities for the two participants. For example, one participant stated,

> I learned a lot about parenting, and I'm still learning. I'm not the best parent in the world, but I'm not the worst either. I know that I have a very honest relationship with my kids. It is pretty deep because I've been through a lot and they have been through a lot too.

Intimate relationships were marked by reciprocity. Being loved and giving love, receiving support and providing it, and shared efforts in resolving intimate conflicts were important aspects of their relationships with their partners. For instance, "love, respect, honesty, caring, limits, boundaries, and life" represented what one participant and her husband brought to each other in their relationship. The following quotation illustrates how this participant worked through conflict with her husband:

> We talk about it. There are times we may need some space before we are ready to process what had happened. But we do talk about it and it's never "you did this" or accusatory. It's, "when you said this, this is how I felt, this is how I reacted." And most of the time we find that there has been a misunderstanding. There are times when my husband may be having a rough time and he just needs to talk. He just needs support and validation just the way I do.

Finally, spiritual support was significant for one participant. Her relationships with God helped her to find strength and serenity, especially when she was confronted with difficult situations.

Meaning of work. As shown in Table 2, work was a means of self-actualization for the two participants. For five years, they each had been working in jobs that were in line with their interests. One participant designed her job as a mental health consultant. She stated,

> I have to know that I am doing something that is meaningful for me, whether it is teaching kids or doing social change. If it is not personal at all, I couldn't do it. I always created my own job.

They both were satisfied with their jobs, which offered them opportunities to further improve their abilities and to challenge themselves. Work also provided social meaning for the person working as a mental health consultant. She was actively engaged in advocating for the rights of persons with psychiatric disabilities. Making social changes was an important *raison d'être* for this participant.

Vocational future. The two participants perceived their vocational future as promising. One participant wanted to continue working as a mental health consultant and to start doctoral studies. The other participant wanted to make a career transition, shifting from the field of management to computers. Both participants were aware of the time and energy required to achieve their vocational goals. They appraised these goals as new "challenges." They both had started to prepare themselves for these changes in their careers by reading material related to these new interests.

Meaning of recovery. For participants belonging to Profile III, recovery was perceived as an ongoing process in which they looked for opportunities to challenge themselves as well as to search for a sense of serenity and peace of mind. Three major aspects were related to this meaning of recovery. First, recovery efforts took place in several domains of the participants' lives, such as work, parental and intimate relationships, in line with their multidimensional sense of self. Second, recovery required daily efforts from participants. Finally, nourishing positive feelings about oneself facilitated recovery. In particular, participants stressed the importance of loving whom they had become. Loving oneself was perceived as a personal resource that participants could tap into when dealing with difficult situations. The following quote illustrates the second and third aspects of recovery:

> Recovery means to me having peace of mind, serenity, focus, and dealing with everyday problems. Having pride in myself and loving myself, I could never say that before. Recovery is living. Recovery is not easy; it is a hard journey at times but every moment of that pain is worth it to get through the other side.

Discussion

This study provides additional support for the important role of work in the recovery of persons with psychiatric disabilities. Vocational activities contributed to the recovery process in two major ways. First, work was perceived as a means of self-empowerment, in line with other studies (Strong, 1998; Young & Ensing, 1999). Second, work promoted a sense of self-actualization, which has been underrepresented in the recovery literature. Another interesting finding was that participation in work was closely linked to the experience of recovery. The three profiles of recovery described the specific contexts in which participation or withdrawal from work can be understood.

Work was a means of passing time for persons in Profile I, who perceived themselves as vulnerable, had a poor sense of empowerment, established few significant contacts with others, had limited hopes about their vocational future, and viewed their recovery as uncertain. These participants appeared to be engulfed by their acceptance of their role as the psychiatric patient (Lally, 1989), which limited their self-empowerment. Their use of passive and avoidance coping strategies, and their tendency to have an external locus of control can also be interpreted as learned helplessness reactions to social stigma (Deegan, 1988; Kramer & Gagne, 1997; Mead & Copeland, 2000). Participants used these strategies to build a secure environment in response to their sense of vulnerability, which was in turn reinforced by past experiences and/or fears of social discrimination. Finally, their limited connections with others may reflect an attitude of positive withdrawal (Corin & Lauzon, 1992, 1994), which is marked by personal detachment from the social world.

For these participants, the reconstruction of a sense of self as an active and responsible agent in recovery would be a major target of intervention. Integrated treatment, in which psychiatric and vocational interventions are both provided, appears critical. On the psychiatric side, strategies for these persons may focus on the development of proactive strategies for managing psychiatric disabilities as well as the acquisition of basic social skills for building meaningful relationships with others. On the vocational side, intervention strategies may focus on the promotion of beliefs in self-efficacy, such as reinforcement of task performance, follow-along supports for skill acquisition and task motivation, group discussion with peers on work values and attitudes, and exposure to employed peers acting as role models (Fabian, 2000).

Work was a means of self-empowerment for persons in Profile II, who were in the process of reconstructing their sense of

self. These participants believed in the possibility of increasing their sense of empowerment and regaining lost aspects of the self. They had a positive outlook on their vocational futures and had benefited from social support. Participants in Profile II bear some similarities to those identified as "becoming a capable person" in Strong's (1998) study, who also viewed work as a means of self-empowerment. Participants in Profile II had started to build a new more functional sense of self (Davidson & Strauss, 1992) based on their involvement in three main life domains. First, they had been successful in their efforts to exert personal control over their psychiatric disabilities. Second, they had experienced pride in performing previous or present vocational activities. Third, they were satisfied with their ways of connecting with others, although most of them wanted to be involved in additional and more fully reciprocal relationships.

For persons in Profile II, supported employment strategies may aim at sustaining individuals in their efforts to develop a sense of self-empowerment. On the psychiatric side, intervention strategies may focus on the acquisition of more advanced social skills, such as those oriented towards validation and conflict resolution. On the vocational side, these persons may benefit from support for job accommodations, assistance in coping with job barriers, and counseling for career development activities (Fabian, 2000). All of these vocational intervention strategies may assist them in sustaining a view of work as a meaningful activity for self-development.

Work was perceived as a means of self-actualization in persons belonging to Profile III. They had a multidimensional sense of self, felt empowered, built satisfying and reciprocal relationships with others, viewed recovery as a challenging process, and believed the future was promising. These participants were characterized by their constant search for learning experiences, as previously reported (Copeland, 2000; Deegan, 2000). Recently, an absence of relationship has been reported between psychiatric self-labeling and vocational self-actualization (Kravetz, Faust, & David, 2000). A multidimensional sense of self, or self-complexity (Linville 1985, 1987; Woolfolk et al., 1999), independent of emotional problems, may be more likely associated with this type of work meaning, as represented in persons belonging to Profile III. Another major characteristic of these participants was their ability to reframe difficulties into challenges and to apply problem-solving skills. This highlights the role of positive reappraisal in recovering from psychiatric disabilities.

At the intervention level, persons in Profile III may serve as role models for peers. They may be viewed as a source of inspiration by those lacking confidence in their abilities to recover and a source of support by those engaged in recovery (Young & Ensing, 1999).

The three profiles of recovery should be seen as preliminary evidence for different ways of experiencing recovery. The small number of participants belonging to each profile and the exploratory nature of this qualitative study underscore the importance of replicating these findings. Longitudinal data are also needed to better understand the evolution of individuals within each profile and among the three profiles over time, including the process of moving from one profile to another one. It is possible that the three profiles represent specific stepping stones in the path of recovery. In summary, the findings suggest that work contributes to the recovery process by providing meaning in one's life. Self-empowerment and self-actualization were two types of meaning that promoted recovery in participants, suggesting their role in mediating the relationships between work and non-vocational areas of functioning.

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