FACTORS ASSOCIATED WITH WORK INTEGRATION FOR MENTAL HEALTH CONSUMERS

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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for Mental Health Consumers

Doctor of Philosophy, 1999

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Abstract
Research on work integration for mental health consumers has typically examined the relationship of clinical and individual variables to employment, and few conclusions have been reached. This study shifts the focus of inquiry to include individually-based variables as well as environmental variables. A mixed method design drawing on quantitative and qualitative approaches was used to examine factors associated with work integration for mental health consumers. Thirty-six consumers (N=36) were recruited into one of two groups: 1) consumers who were employed in integrated settings (n=17) and 2) consumers who had left their jobs within a six-month period prior to the study (n=19). Quantitative data were collected on four variables: empowerment, social support, organizational culture/climate and person-environment fit. Instruments used were the Empowerment Questionnaire, the Interpersonal Support Evaluation List (ISEL), the Workplace Climate Questionnaire (WCQ) and the Organizational Culture Profile (OCP). Data analysis revealed significant group differences along the
dimensions of organizational climate and person-environment fit. Significant differences in effect sizes of perceived characteristics of the workplace were also determined. Logistic regression analyses revealed that organizational climate and person-environment fit were significant predictors of employment status. Qualitative data were collected through semistructured interviews with participants in both groups. Content analysis revealed the following themes: the impact of the organization on job satisfaction and tenure, the importance of supervisory and coworker relationships and attitudes, and the meaningfulness of work.
Acknowledgements

The writing of this thesis has been a meaningful and rewarding experience, both personally and professionally. I would like to express my gratitude to the many people who have provided me with support, encouragement, and insights along this journey.

I gratefully acknowledge the members of my committee for their advice and guidance throughout the development of this project. My thanks and appreciation are extended to my supervisor, Carol Musselman, for her thoughtful suggestions, her responsiveness, and her careful attention to my work. I owe a debt of gratitude to Judith Friedland for inspiring me to embark upon the doctoral journey, for her repeated expressions of confidence in my ability, and for her thoughtful and constructive suggestions. I also wish to thank Peter Lindsay and Uri Shafrir for their intellectual presence, and their sound advice.

I am grateful to the Ontario Institute for Studies in Education (OISE), to the Social Sciences and Humanities Research Council (SSHRC), and to the Canadian Occupational Therapy Foundation (COTF), all of whom provided me with funding for various stages of the research.

I also wish to extend a special thank you to all of the participants in the study. I have been moved and enlightened by the consumers who came forth and trusted me with their experiences, thoughts and feelings. It is my hope that, in some small fashion, this thesis rewards their efforts with a heightened attentiveness to workplace issues.
My most heartfelt thanks are extended to my family, without whom this thesis could not have been accomplished. My husband, Jon, who humoured me, energized me, and accommodated my working needs, has been my inspiration throughout the entire process. My children, Adam, Maya and Emily, who so openly expressed excitement and pride in my work, have been my source of joy in the face of challenge. The love and support provided to me by my family have been enormously important influences in the pursuit of this goal.
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Introduction

Employment is a major issue affecting health and well-being, yet integration into the workplace has been an enormous challenge for consumers* of mental health services. The glaring underrepresentation of people with serious mental illness in the labour force has been documented (Blankertz & Robinson, 1996; Department of Secretary of State, 1990) as has the need for increased and enhanced employment opportunities for mental health consumers (Lord, Schnarr & Hutchison, 1987; Ontario Ministry of Health, 1993). Increased employment is a priority which has been clearly identified by consumers, government and families. A qualitative study by Lord, Schnarr and Hutchison (1993) focusing on community needs of mental health consumers revealed that employment was the one need noted most often and most emphatically. Surveys of consumers indicate that a majority want to work, and are able to cite preferences for specific work situations (Becker, Bebout & Drake, 1998; Holley, Hodges & Jeffers, 1998). Consumer groups such as the Residents' Association of Toronto have articulated their vision of mental health services and supports, emphasizing "jobs" as a primary theme in a document entitled What About Work and Other Questions? (Reville, 1991). Health promotion materials in Ontario such as the Premier's Council on Health Strategy (1990) suggest

*'Consumers' is used as a term for those who identify themselves as persons with psychiatric disabilities. "The term consumer is preferred because it implies freedom of choice in the use of professional services, despite the reality that many mental health consumers are force-fed" (Kaufmann, Freund & Wilson, 1989, p.5).
that secure jobs and opportunities to make changes in the workplace are important factors affecting health. The Provincial Community Mental Health Committee (1988), in its plan for mental health service delivery in Ontario, emphasized the importance of identifying necessary vocational supports and assessing the ability of the job market to respond to defined needs through consultation from consumers, agencies and employers (p.53). In the report Framework for Support which was adopted as a policy document by the Ministry of Health, work was defined as a fundamental determinant of health: "without the fundamentals such as jobs...people are pushed to the margins of society and deprived of the kinds of support that they need if they are to survive the challenges of living with a mental illness" (Trainor, Pomeroy & Pape, 1993 p. 14). Ontario’s plan for mental health reform further emphasizes that in order to meet mental health needs, the mental health system must address the broad determinants of health, including employment opportunities (Ontario Ministry of Health, 1993, p.3).

The relationship between employment and physical and mental health has been examined extensively in the general population, but information regarding employment and consumers of the mental health system is not only inadequate but conflicting. Little is known about predictors of positive vocational outcomes or influences on the process of work integration itself. Efforts in the area of vocational rehabilitation have, to date, focused on the individual through skill building and behavioural change with little attention to social and environmental factors affecting employment, and have
met with limited success. There is clearly a need for a deeper understanding of factors affecting the process and outcomes of work integration for mental health consumers. To offer insight into this area, this research examines variables associated with employment and explores the meaning of work for consumers of mental health services. The research aims to: 1) answer substantive questions and contribute to theory about the experience of work reintegration for mental health consumers; 2) promote understanding of the meaning of work for mental health consumers; and 3) examine how individual and environmental issues impact on the process of work integration. The unique contribution of this work is its focus on interactions between the individual and the social and environmental factors which facilitate employment. This focus is in contrast to traditional approaches, relating pathology to outcomes, which have dominated research to date. Thus, a primary goal of this research is to shift the existing individually-based orientation to one of contextualization by examining social and environmental issues that influence the process of work integration.

Hypotheses

A pilot study was carried out by this investigator (Kirsh, 1996) in the area of employment integration for mental health consumers which examined the problem from the perspective of the consumers themselves. This study, now published in the Canadian Journal of Community Mental Health, revealed several important themes related to successful employment, including: (1) the
relationship of a sense of empowerment to successful work integration; (2) the need for social support; and (3) the importance of the climate and culture of the work environment. In light of these findings, it was hypothesized that strength in each of these areas would be associated with positive vocational outcomes. Specifically, the following hypotheses were tested: (1) that differences in perceived empowerment exist between employed and unemployed groups (i.e., higher levels of perceived empowerment are associated with employment); (2) that differences in perceived social support exist between groups (i.e., social support which is perceived to be sufficient and satisfying is associated with employment); (3) that differences in organizational climate exist between employed and unemployed groups; and (4) that work environments which provide high levels of person-environment "fit" are related to successful work integration. These four hypotheses provided a framework for guiding the information collection and analysis process.
Chapter One: Literature Review

The Work-Health Relationship

The value of work in meeting basic needs and providing both monetary and non-monetary benefits has frequently been demonstrated. Employment provides structure to time, a sense of status and identity, the opportunity to share experiences with others and to identify with goals and purposes that extend beyond one's own. People view employment as a major source of psychosocial well-being and experience or seek out at the workplace opportunities for responsibility, creativity, friendship, recognition and pride (Canadian Mental Health Association, 1984). Benefits of the work identity are numerous. A recent qualitative study exploring meanings individuals attach to role identities identified independence/self-sufficiency, meeting challenges/attaining goals, responsibility/stability, helping others/making a contribution, belonging, and identity/self worth as enriching components of the work identity (Simon, 1997).

Employment has been found to be a powerful predictor of health status; in fact, evidence exists that capacity to work and consistency of employment experience are better predictors of positive psychological health than such variables as social class and multi-problem family membership (Vaillant & Vaillant, 1981). The Canada Health Survey conducted in 1981 indicated that "active" Canadians, defined as those employed or in school, reported lower frequency of physical and mental health problems and expressed psychological well being more often than "inactive" people
(Statistics Canada & Health & Welfare Canada, 1981). In a longitudinal study examining the impact of employment and unemployment on health and well-being, Graetz (1993) showed that employed people reported significantly lower levels of health disorder than unemployed persons. Similarly, an analysis of Statistics Canada’s 1989 General Social Survey found that people employed in secure jobs reported greater health and life satisfaction than those who were unemployed or in insecure jobs (Grayson, 1993).

The relationship between work and health appears to exist in other cultures as well. Abramson, Ritter, Gofin and Kark (1992) found workers in Israel were healthier than nonworkers with respect to general, physical and emotional health and a Finnish longitudinal study interpreting census data found a lower mortality rate in employed than unemployed people after controlling for age, education, type of occupation and marital status (Martikainen & Volkonen, 1996). A prospective study of over 6000 British men continuously employed for the five years prior to screening found that those who became unemployed or retired during the five years after screening were twice as likely to die in the 5.5 years that followed as men who remained employed (Morris, Cook & Shaper, 1994).

Studies focusing on women have resulted in similar findings. Wheeler, Lee and Loe (1983) found that employed women had a higher sense of well-being and utilized fewer professional services to cope with personal and mental health problems than their non-
employed counterparts. Cross-sectional studies reveal that depressive symptoms in particular have been found to be fewer in employed women as compared to unemployed women (Bromberger & Matthews, 1994; Cochrane & Stopes-Roe, 1981).

The high value placed on employment is reflected in studies showing reduced depressive symptomatology in employed women as compared to those who are homemakers (Glass & Fujimoto, 1994) and this appears to hold true in a variety of contexts. For example, a large study on women, employment and parenthood conducted in Norway indicated that problems of coping, dissatisfaction with life, depression and loneliness were greatest among non-employed homemakers, particularly among those with young children (Sogaard, Kritz-Silverstein & Wingard, 1994). Similarly, investigations of the influence of paid work on the perceived health state in women conducted in Spain revealed twice as many homemakers as workers reporting poor self-perceived health, leading the authors to conclude that paid work has a positive relationship to women’s self-perceived health status (Rohlfs, de Andres, Artazcoz, Ribalta & Borrell, 1997). Some longitudinal evidence also exists that employment appears to improve the health of married and unmarried women who have positive attitudes towards employment (Repetti, Matthews & Waldron, 1989). However, Bromberger and Matthews’ (1994) longitudinal study of women and unemployment suggests that newly employed women benefit most in terms of reduction of depressive symptoms, leading them to speculate that under conditions of low life stress, employment has the potential to enhance mental health.
whereas under stressful life circumstances the positive effects of employment may be suppressed.

A recent and striking finding regarding women and work is discussed in Burr, McCall and Powell-Griner’s (1997) investigation of female labour force participation and suicide. Their findings suggest that occupying multiple roles may serve to reduce women’s risk of suicide and that, furthermore, men actually appear to receive some protection from suicide when women are in the paid work force.

The significant role of employment in promoting and maintaining health, and in particular mental health, is accentuated by evidence pointing to negative consequences in its absence. A large body of literature examining relationships between unemployment, illness and mortality exists through both aggregate-level and individual-level research. Brenner’s (1976, 1977, 1979, 1983, 1987) ground-breaking and controversial work has demonstrated a strong association between unemployment and various forms of ill-health. Using aggregate time-series analysis to compare indicators of economic fluctuation to patterns of change in indices of health status, his studies emphasized that pathological reactions to unemployment will follow actual job loss at a variable length of time. In one U.S. study, Brenner (1976) investigated statistical relationships between increases in general economic indicators such as unemployment and rises in general stress indicators. Significant correlations were found between a sustained rise of 1.4% in the level of unemployment over four years and a rise in mortality from
various causes as well as a rise in admittance rates to hospitals, prisons and other institutions. Using techniques similar to Brenner's, a Canadian researcher, Adams (1981) analyzed national employment and mortality data for the period from 1950 to 1977 and found a significant positive relationship between unemployment and heart disease. Other aggregate level studies show a strong positive correlation between economic insecurity and rates of suicide (Catalano, 1991; Dooley & Catalano, 1984).

Individual level research in the area of unemployment and health concurs, suggesting that the physical, psychological and spiritual distress experienced by those who have been deprived of their occupational role is profound. Shortt (1996) reviewed plant closure studies and concluded that job loss adversely affects the physical and particularly the mental health of former workers. In a variety of studies, previously healthy workers rendered unemployed as a group through no fault of their own displayed identifiable changes in status after job loss. Cobb and Kasl (1977), in their longitudinal study of workers who had their jobs terminated, found increased anxiety, pessimism, anger, depression and insomnia. In their prospective study of men who became unemployed, Linn, Sandifer and Stein (1985) found that symptoms of somatization, depression and anxiety were significantly greater in the unemployed than in the employed. Most frequently, cardiovascular disease, increased sick role behaviour, isolation, alcohol use and depression are evidenced in studies of unemployment (Iversen, Sabroe and Damsgaard, 1989; Joelson & Wahlquist, 1987).
In a study examining the association between unemployment and risk of medically serious suicide attempts, individuals who attempted suicide reported higher rates of current unemployment than their community counterparts; after adjustment for antecedent childhood, family and educational factors the association between unemployment and risk of serious suicide remained significant (Beautrais, Joyce & Mulder, 1998). As Mathers and Schofield (1998) have summarized, the psychosocial impacts of unemployment are manifold and include loss of a sense of identity, lowered self-esteem, marginalization and alienation from society, limited social support, loss of networks, and social stigma.

Negative effects of unemployment have been documented throughout the lifespan. For example, teenagers moving from school into unemployment are likely to experience a significant drop in well-being, whereas those entering paid work are likely to exhibit improvement (Tiggemann & Winefield, 1984). A large prospective Swedish study showed increased psychosomatic symptomatology, decreased social activities, increased drug and alcohol use and increased utilization of health services amongst youth who failed to find employment as compared to their employed peers (Hammarstrom, Urban & Theorell, 1988). Pritchard (1992) noted significant correlations between unemployment and suicide trends amongst youth in nine of twelve European countries he studied. Research conducted at the other end of the life-stage continuum concurs, for the most part. A study of mandatory retirement has shown adverse psychological and physiological results,
specifically, a surprising increase in mortality rates in previously healthy individuals (Somers, 1981). However in their longitudinal study, Reitzes, Mutran and Fernandez (1996) reported mixed findings, that is, when retirees were compared with those who continued to work, retirement had a negative influence on depression but a positive influence on self-esteem.

Work and Mental Health Consumers

In contrast to the abundance of literature on the psychosocial and physical benefits of work and the negative consequences of unemployment for the general population, research in this area with regard to persons with psychiatric illnesses is just beginning to develop. Reviews of the literature in this area suggest that, like other populations, mental health consumers benefit from the effects of employment.

Work has been described as a "competing process to symptoms" (Russert & Frey, 1991, p.9), and several studies appear to substantiate this claim. Bell and Lysaker (1996, 1997) found that individuals with schizophrenia or schizoaffective disorder involved in a six-month paid work opportunity showed significantly greater improvement in symptoms than their non-paid counterparts both during the assignment and at one-year followup. Mueser et al. (1997) showed that formerly unemployed psychiatric patients who obtained competitive employment while participating in a vocational program tended to have lower symptoms, better overall functioning and higher self-esteem after controlling for baseline levels of
these variables. Similarly, Scheid (1993) found clients who were working had fewer psychiatric symptoms, were more able to complete basic living tasks, and had better physical health and fewer side effects than the nonworking comparison group. Both Warner (1985) and Warr (1987) also found that working clients functioned better. In all of these studies, however, it was unclear whether employment resulted in improvement or whether those with higher levels of functioning were more able to work. However employment as a causal factor of higher functioning is suggested by Bond and Dincin (1986) who showed improved outcome for clients who returned to work in an accelerated fashion as compared to those assigned to standard job placement in their study of clients randomly assigned to these two groups. In fact, it appears that employment may have an effect on subjective indicators related to improved functioning. Arns and Linney (1993) compared change in vocational status to subjective evaluation of self-efficacy and self-esteem in a population of mental health consumers and found that a six-month change in vocational status was significantly associated with increased self-esteem and an enhanced sense of self-efficacy.

Uncertainty exists around the relationship of work to hospitalization. For example, Bell and Lysaker (1996; 1997) found that rehospitalization rates, which were significantly lower for a paid group of consumers during their work assignment, were no different at one-year followup. Furthermore, a predictor study using regression analysis (Doering et al., 1998) revealed that more than nine months of employment predicted a higher relapse risk in
one treatment group, while the same factor coincided with a lower rehospitalization rate in another group of patients. The investigators could only attribute this discrepancy to random variation.

Despite the generally positive findings around the relationship of work to mental health consumers, little is known about the meaning of work to individuals with mental illness. There is a general assertion in the psychiatric rehabilitation literature that work contributes to and improves quality of life for individuals with severe mental illness (Anthony & Blanch, 1987). However, studies in this area are few and present complex and divergent results. Bell and Lysaker (1995, 1996) found that individuals in paid work experiences experienced feelings of well-being and personal satisfaction, yet about half dropped out of the paid work experience and 30 per cent chose to engage in no productive activity in the six months following completion of the experience. Mueser et al. (1997) did find higher satisfaction with vocational services and finances amongst working consumers but results failed to show a relationship between work and overall life satisfaction, leading the authors to conclude that "employment does not lead to a generalized improvement in subjective quality of life" (p. 424). Lehman (1983) found work variables to be highly correlated with perceived well-being in a chronically mentally ill population, but this relationship applied only to a small number of participants who were employed. Similarly, Fabian (1992) found an increase in scores on subjective quality of life scales in
individuals with severe mental illness engaged in supported employment as compared to nonworking individuals. This finding, however, is in direct contrast to findings in her earlier work (Fabian, 1989) in which she found no significant differences on objective or subjective quality of life indicators when comparing two samples of employed and nonemployed consumers. The investigator speculated that a potential explanation for the finding in this earlier study can be found in social comparison research which suggests that one compares one’s status to similar reference groups in reaching an evaluation of one’s well-being. It is probable that the participants of the study had as their reference group a nonworking population.

The inconsistency of these results with those of studies on "normal" populations brings into question the universality of the work benefit. The difficulty in characterizing and capturing the meaning of work is further illustrated in Scheid and Anderson’s (1995) qualitative study of working consumers. Although all 10 participants in this study felt work was important to their sense of self-identity, some of them also identified work as a source of stress and feared that full-time work might be too overwhelming. Thus, the true meaning and impact of work on the lives of mental health consumers remains unclear. As suggested by Scheid (1993), further studies that access work experiences over time are needed to determine whether work "improves self-esteem and psychiatric state or is a source of additional stress that can result in reduced self worth and depression" (p. 775). Furthermore, Fabian
(1992) emphasized the need for qualitative research to complement quantitative methods in light of the independence of objective and subjective quality of life scales.

**Variables Associated With Employment Amongst Mental Health Consumers**

The lack of clarity around the meaning and effects of work as well as factors which facilitate work integration amongst the psychiatric population is no doubt related to its underinvestigation. The paucity of knowledge in this area may be reflective of the fact that many people see unemployment as an inevitable consequence of mental illness. A recent study examining views of patients, providers and families around community integration revealed that, compared with clinical care providers, patients expressed more optimistic views and hopes about their future work prospects. Although staff believed that most patients were not employable, a majority of patients expressed a desire to work (Holley, Hodges & Jeffers, 1998). Low expectations, social stigma and other factors have resulted in denial of opportunities for mental health consumers to enter the labour force, and this continues to be true today. Dependence on public financial assistance often begins very early in the course of illness and is maintained for long periods of time (Ho, Andreasen & Flaum, 1997). Studies indicate that, at follow-up, only 20 to 25 per cent of persons discharged from psychiatric hospitals are engaged in work activity including supported, sheltered, and competitive employment.
(Anthony, Buell, Sharratt & Altoff, 1972; Anthony, Cohen & Vitalo, 1978, Anthony & Dion, 1986). Even fewer, less than 15 percent of psychiatrically disabled persons, are competitively employed (Anthony & Blanch, 1987; Blankertz & Robinson, 1996; Farkas, Rogers & Thurer, 1987; Tessler & Goldman, 1982; Wasylenki, Goering, Lancee, Ballantyne & Farkas, 1985). Even programs designed for and geared towards persons with severe mental illness are associated with low rates of competitive employment (Jacobs, Wissusik, Collier, Stackman & Burkeman, 1992; Marshak, Bostick & Turton, 1990). Sadly, compared to other forms of disability, psychiatric disorders have had the lowest success rates of vocational rehabilitation (Andrews, Barker, Pittman, Mars, Struening & LaRocca, 1992; McCue & Katz-Garris, 1983).

Reasons for this rather dismal state of affairs remain unclear. Work that has been done in the field to date focuses primarily on the individual with mental illness and the relationship between existing pathology and employment. Although some studies do suggest a relationship between symptomatology and work skills, findings conflict and the relationship is one that is not well understood. After comparing psychiatric clients of different work status, Scheid (1993) commented on the lack of data demonstrating that psychiatric disability negatively impinges on the ability of clients to work. Similarly, in a study investigating factors predicting employment outcomes for people with chronic psychiatric illnesses, only two measures of functional performance (attendance and ability to relate to authority) and a measure of
psychiatric impairment (number of previous hospital admissions) were significantly correlated with employment outcomes, leading the investigator to state: "this poses a doubt in the link between functional performance and employment outcomes, and also reminds us of the lack of relationship between measures of psychiatric impairment and employment outcomes" (Siu, 1997, p. 56) A number of other studies also illustrate the lack of relationship between assessment of psychiatric symptomatology and future work performance (Ciardiello, Klein & Solkowski, 1988; Moller, vonZerssssen, Werner-Eilert & Wuschenr-Stockheim, 1982; Strauss & Carpenter, 1972, 1974). In contrast, however, other studies suggest that clinical indicators may, in fact, have some predictive value. Anthony, Rogers, Cohen and Davies (1995) found a moderate negative relationship between ratings of symptoms and ratings of work skills, but only about 10 to 15 percent of the variability in work skills was accounted for by symptomatology. Both Hoffman and Kupper (1997) and Bell and Lysaker (1995) found that symptoms had an impact on work capacity but this relationship was true mostly for cognitive components, and not for positive symptoms of the illness. Rogers, Anthony, Cohen and Davies (1997) found that symptomatology did account for a significant percentage of the variance in vocational functioning. However, in both the Bell and Lysaker study (1995) and the Rogers, Anthony et al. study (1997), symptoms were only able to predict work performance when measured concurrently. In the latter study, for example, symptoms measured at two points in time 13 weeks apart, accounted for only eight per
cent of the variance in one aspect of work skills. Furthermore, Lysaker and Bell (1995) demonstrated that, although persons with negative symptoms of schizophrenia had poorer "task orientation," "social skills," and "personal presentation" than those without negative symptoms, they were unable to find significant differences in "work motivation" and "work conformance."

The question of whether a relationship exists between diagnostic category and future work performance is equally puzzling. Anthony and Jansen (1984) cited a number of studies demonstrating the absence of such a relationship (Moller et al., 1982; Sturm & Lipton, 1967; Watts & Bennett, 1977) in their review of predictors of vocational capacity of the chronically mentally ill. However, recent reviews present variable and conflicting results. Jacobs, Wissusik, Collier, Stackman and Burkeman (1992) examined the effects of a job club intervention on 89 persons with severe mental illness and found that persons with psychotic disorders such as schizophrenia or bipolar disorder were less likely to obtain jobs than persons with other disorders. Fabian (1992) studied 90 persons in a supported employment program and found that having a diagnosis of schizophrenia and being of a minority race were associated with poorer vocational outcomes. In contrast, Rogers, Anthony, et al. (1997) found that diagnostic category was not predictive of work outcomes.

Other individual characteristics have also been investigated but have failed to provide conclusive or even consistent findings on predictors of employment. Despite early work correlating both
premorbid employment history (Anthony & Buell, 1974; Strauss & Carpenter, 1974) and premorbid ability to function (Griffiths, 1974; Strauss & Carpenter, 1974) with future work performance, more recent research by Solinski, Jackson and Bell (1992) has failed to replicate either of these relationships. Conflicting results have also been documented regarding levels of work performance as assessed by vocational programs. Anthony and Jansen (1984) stated that the best clinical predictors of future vocational performance were ratings of work adjustment skills in a workshop setting, whereas Hoffmann and Kuper (1997) found that work performance at the intake stage of a vocational rehabilitation program had only poor predictive value for future vocational outcome. Still other individual traits have been investigated through psychological tests such as the WAIS, Rorschach and MMPI, but these also have not been useful as predictors of employment potential (Webster, 1979). It may be stated that the predictive value of all of the clinical indicators examined to date, are at best, questionable.

The lack of clarity regarding the relationship of individual variables to employment outcomes suggests that there may be other factors that need to be taken into account. Thus, there is a need and rationale for combining approaches which examine individual variables with those that focus on the larger social environment, so that a deeper understanding of the complexities which surround the process and outcomes of work integration for mental health consumers may be achieved. External or environmentally-based variables which may be significant have been identified from a
review of return-to-work literature for other populations and from earlier work of this investigator (Kirsh, 1996). Such areas as empowerment, perceived social support, the climate and culture of the work environment, and person-environment "fit" have been identified as issues in need of further exploration relative to workplace integration of mental health consumers.
Chapter 2: Empowerment

Empowerment: A conceptual analysis

The surge of interest in empowerment in the fields of psychology, sociology, education, organizational development, public health and politics points to its popularity as a vital potential construct for understanding human development and interactions at many levels. In fact, empowerment is a term so widely used in today's society that attempts to formulate a unified definition and set of operational principles are elusive, perhaps even impossible. However, important themes and principles reverberate through discussions of empowerment and its applications. A review of relevant literature on empowerment theory and research will provide an understanding of current conceptualizations of the term and will frame the attributes of empowerment most closely linked with this study.

The works of Paulo Freire are important pieces in the analysis of the concept of empowerment. Freire, a leader of international literacy campaigns, maintained that oppressed, disempowered people "struggle for their lost humanity...(because of) humans' ontological vocation" (Freire, 1970, p. 28) and explained the process of "conscientization" (Freire, 1986), in which people, "not as recipients, but as knowing subjects, achieve a deepening awareness of the sociological reality which shapes their lives and their capacity to transform that reality" (cited in Simon, 1994, p. 140). Inherent in this process are a number of principles that have been carried forward into current conceptualizations and
applications of empowerment theory.

Most prominent is the importance of the context in which people's experiences are embedded and the need to focus not only on individuals' abilities to meet their needs but also on the structural inequities that profoundly influence ways in which people are able to gain control over their lives. Rappaport (1987) reflected concern with both the psychological sense of personal control and social influence, political power and legal rights in his definition of empowerment: "a mechanism by which people, organizations and communities gain mastery over their affairs" (p. 122). He described the study of empowerment as "the study of people in context" (p.121). Riger (1993) emphasized that the study of empowerment must include not only core concepts such as agency, mastery and control, but also the role of connectedness in human life, as both, she claimed, are integral to human well being and to well-functioning communities. Perkins and Zimmerman (1995) also addressed this important duality by stating that "empowerment theory, research, and intervention link individual well-being with the larger social and political environment" (p. 569). Foster-Fishman and Keys (1997) drew on the work of Rich, Edelstein, Hallman and Wandersman (1995) in offering a caveat to the study of empowerment: "if we ignore this person-environment interaction and the critical role that both individual and contextual characteristics play...we risk implementing ill-fated empowerment initiatives, or worse yet, creating disempowering experiences for the participants" (p. 347).
A concern with empowerment as both a personal and ecological construct reduces the risk of assuming a single perspective and placing full responsibility, or even blame upon the individual. Empowerment is clearly a multilevel construct which includes both personal abilities and external contexts, described by Zimmerman (1995) as one which invites analysis at individual, organizational and community levels.

While the importance of attending to contextual elements must be pointed out, it must also be stated that personal and individual dimensions are critical to the study of empowerment and its effects. Issues of self-esteem, mastery and self-efficacy are central to the concept of empowerment. The relationship between empowerment and the self has been explored by Zerwekh (1983) who maintained that power originates in self-esteem developed through love, responsibility, opportunities for choice and perceived meaning and hope. Rodwell (1996) also focused on self-esteem, defining empowerment as "a process of transferring power [which] includes the development of a positive self esteem and recognition of the worth of self and others" (p. 307). The cyclical and interdependent nature of valuing the self and others, recognizing personal competencies, and perceiving the self as efficacious is deeply embedded in empowerment theory. Bandura (1982) suggested that those individuals who possess a strong sense of self-efficacy mobilize their energies to address the demands of the situation and are in fact spurred on to greater effort by obstacles. Ozer and Bandura (1990) made direct links to empowerment, when they defined
the concept of empowerment in terms of the manifestation of people's belief in their efficacy and in addition, described personal empowerment through mastery experiences as a powerful means of creating a strong, resilient sense of efficacy (Bandura, 1992). Lord and Hutchison (1993), in their study of persons making the transition from powerlessness to empowerment, noted that mobilization of an individual's internal resources (e.g., self-efficacy) contributes to increased personal empowerment, explaining that "people's belief in their own capabilities and unique personal characteristics helped foster confidence in their ability to take initiative in changing their lives" (p. 18). Exemplars of empowerment cited in the literature lend further support to the necessary focus on individual mastery and self-efficacy: often included in these descriptions are competence-building programs aimed at increasing self-efficacy, confidence and skills (Freedman, 1993; Perkins, 1995).

Self-efficacy, in and of itself, is considered by many to be insufficient to characterize empowerment. Rather it must be placed within the context of the social and political environment that is related to action to more aptly capture the concept. For example, Rubin and Rubin (1992) defined empowerment as the sense of efficacy that occurs when people realize they can solve problems they face and have the right to contest unjust conditions. Zimmerman (in press) specified that "psychological empowerment includes beliefs about one's competence and efficacy, and a willingness to become involved in activities to exert control in the social and political
environment." Community activism has become an important component within the iterative and interactive processes involving self-esteem, mastery, self-efficacy and action.

Most of the literature associates empowerment with personal control and there has been much debate around the nature of this control, particularly with regard to actual versus perceived control. Some literature emphasizes the sense of personal control as the critical issue defining the concept. Zimmerman (1995), for example, described psychological empowerment as a construct within which perceptions of personal control, a proactive approach to life and a critical understanding of the sociopolitical environment are integrated. Ozer and Bandura's (1990) focus, as previously stated, was also on perceived self-efficacy and belief in one's capabilities, and others have identified results of empowerment as a sense of control over life and the change process (French, 1990; Mason, Backer & Georges, 1991; Zerwekh, 1992). Kieffer (1984) conducted a study of community leaders and described "the fundamental empowering transformation...from sense of self as helpless victim to acceptance of self as assertive and efficacious citizen" (p.32), again suggesting perception as the key issue.

However many definitions of empowerment emphasize actual, as opposed to perceived control and influence, through inclusion of statements reflecting participation in and control over social and political structures that affect peoples' lives (e.g. Rappaport, 1987). Foster-Fishman and Keys (1997) explicitly stated that empowerment endeavours must facilitate a process which results in
realized (not simply perceived) control and influence in important life domains. Hall and Nelson (1996), pointed out that empowerment strategies documented in the literature have, as a common point, a focus on situations in which perceptions of personal power are grounded in actual experiences of power. Advocates of this position argue that the focus on actual control is associated with the primary purpose for adopting the construct of empowerment, that is, the enhancement of people’s control over their lives.

Empowerment has been described as both a process and an outcome. Kieffer (1984) examined personal empowerment as a developmental process which includes four stages: entry, advancement, incorporation, and commitment. Lord and Hutchison (1993) described the transition toward personal empowerment as a uniquely individual and ongoing process. Empowering processes may be described as those in which people create or are given opportunities to control their lives and influence decisions that affect them (Zimmerman, 1995). Empowerment outcomes, on the other hand, refer to operationalizations of empowerment that enable the study of the consequences of empowering processes (Perkins & Zimmerman, 1995). Rodwell’s (1996) reminder that "the product is embedded in the process" is a useful one in considering empowerment as an outcome. She included enhanced self-esteem, the ability to set and reach goals and a sense of control over life as indicators of empowerment. Sherwin (1992) argued that empowerment is an outcome of changes in fundamental structures and relations of power and Mason, Backer and Georges (1991) described empowerment outcomes
as confirmation of values and abilities associated with a sense of hope and direction. The question of how to recognize and define empowerment outcomes remains a difficult one because of the existence of differences in conceptualizations. However, as Zimmerman (1995) pointed out, themes around mastery and control, resource mobilization, and sociopolitical context and participation are to be expected because research on empowerment has consistently found these variables to be central to the construct.

**Empowerment and Mental Health Consumers**

The anguish of powerlessness has been described by persons with severe mental illnesses in a multitude of ways (Capponi, 1992; Deegan, 1996; Leete, 1988; Whyte, 1997). Although difficulties performing life tasks as a function of illness are no doubt related to feelings of low self-esteem and loss of self-confidence, these feelings are exacerbated by societal discrimination and limited opportunities for individuals with mental illnesses to contribute to their communities. Research shows that people who have been labelled because of their disability, experience powerlessness as a result of social isolation, segregation, low expectations, and unresponsive community support services (Lord, 1991), and this is particularly true of consumers of mental health services. The stigma and negative identity of "mental patient," which so often becomes internalized, results in a sense of lack of self-worth and hopelessness, in other words, disempowerment. So pervasive and insidious is this societal discrimination that Whyte (1997),
speaking from a consumer perspective, has stated that "oppression is an unplanned side effect in the treatment of mental illness" (p. 22). It is interesting, as Lord and Dufort (1996) point out, that although there have been a growing number of consumer accounts dealing with oppression in the literature, the exclusion of this material from mainstream mental health or psychology "illustrates the dynamics of professional hegemony" (p. 6). Furthermore, they state, there has been little theorizing about oppression in mental health and point out the importance of studying oppression and empowerment as a basis for theory-building.

Research with consumers suggests that a direct relationship exists between perceived control over their lives and overall life satisfaction (Rosenfield, 1992; Segal, Silverman & Temkin, 1995; Rogers, Chamberlin, Ellison & Crean, 1997). Theory in the area of quality of life explains that a "symmetrical relationship" exists between personal control and satisfaction outcomes (Reich & Zautra, 1983). Perceptions of empowerment have been linked to "satisfaction with living arrangements, social relations, family relationships, prevocational activities, safety, health and leisure activities" (Rosenfield & NeeseTodd, 1993, p.77). Measures of empowerment have been significantly correlated with independent functioning, positive affect, and measures of adaptation (Hall & Nelson, 1996). Empowerment is, in fact, viewed by some people within the field of psychosocial rehabilitation as the mechanism which facilitates recovery from mental illness itself (Anthony, 1991, 1993). Mental health consumers emphasize the significance of a sense of
empowerment in becoming able to control their own lives, a process
critical to successful community integration.

Consumer voices are becoming increasingly heard, understood, and valued in the planning and delivery of mental health services. Recognition of and reaction to inequities has involved the experience of anger, and the process of harnessing this anger and frustration into action. Anger has been described as an adaptive, protective reaction to an unjust system which is necessary in the shift from oppression to empowerment (Whyte, 1996):

Anger warns that someone or something has invaded our personal space. Anger expressed can lead to clearer boundaries, increased communication, and mutual respect. Anger can create positive energy for personal and societal change (Whyte, 1996, p. 21).

Researchers who have studied empowerment also place emphasis on the experience of anger. Lord (1991), for example, stated that the process of becoming empowered often begins in response to an external occurrence or crisis, which interacts with the individual’s frustration or anger. Others have described anger as an emotion which leads to acceptance and coping which may lead to a sense of control and empowerment (Spaniol, Koehler, & Hutchinson, 1995). Anger may be the initial stage of a process which mobilizes individuals and groups to exercise their rights and exert influence over decisions which affect their health and their lives.

Consumer participation and action are now being evidenced in a multiplicity of levels and formats, from participation within the formal mental health system (for example, participation on hospital boards and committees), to coalitions and partnerships (such as the
Ontario Quality of Care Coalition), to consumer-controlled activities (for example, consumer-based businesses and advocacy groups) and research (participatory action research in particular). Benefits of consumer involvement have not been documented to a great extent in an empirical way, but some suggestions regarding its direct relationship to empowerment have been made. At the individual level, increased self-esteem and self-confidence and an enhanced sense of well-being are outcomes described in the literature (Wilson, 1996). Improved coping with life skills, economics and opportunities for more satisfying social supports have also been documented (Hutchison et al., 1986; Morrell-Bellai & Boydell, 1994; Nikkel, Smith & Edwards, 1992; Torrey, Mead & Ross, 1998; Woodside, Cikalo, & Pawlick, 1995). A recent evaluation of the Consumer-Survivor Development Initiative in Ontario indicated positive effects of consumer involvement on measures of self-confidence, being in control, having choices, daily coping, contact with others, and involvement in the community (Trainor, Shepherd, Boydell, Leff, & Crawford, 1996). In addition to these positive impacts, involvement may also be of benefit on a system level, through higher quality services that address expressed needs, protect consumer rights, maintain consumer dignity and integrity and decrease stigma (Salzer, 1997). Increased participation in community life has been discussed as an important element of empowerment in a conceptual sense, and indeed it appears that empowerment as a function of consumer involvement contributes to positive outcomes.
Empowerment and Employment

Research on empowerment and employment is extremely limited with respect to mental health consumers. However return-to-work studies with other populations shed some light on this potential relationship. Although the concept of empowerment and employment are not yet related in the literature, there is some research on control (a core component of empowerment) and employment. In a longitudinal study of unemployed healthy persons, Wanberg (1997) found that higher levels of perceived situational control were associated with increased proactive job seeking and positive self-assessment. Similarly, a study of persons who experienced a first myocardial infarction revealed that those who returned to work within two months of their infarct were more likely to have an internal locus of control as compared with those who had not returned to work (Abbott & Berry, 1991). Research with adults with cognitive and developmental disabilities also points to a relationship between control and employment. In one study unemployed individuals and those in sheltered settings perceived themselves as having less control than individuals employed competitively (Wehmeyer, 1994). In another study, persons with traumatic brain injury who did not return to their pre-injury level of employment were found to have lower locus of control scores and higher Powerful Others locus of control beliefs than the group who returned to their pre-injury status (Lubusko, Moore, Stambrook, & Gill, 1994). The issue of control has also been identified as a key factor in promoting return-to-work amongst those who have
sustained injury or physical disability and lies at the core of the rationale for early intervention. Roessler (1989) cautioned against allowing disabled workers to transfer power and control from themselves to medical, legal and rehabilitation providers, and stated that this can be prevented by "early intervention (which) is successful because it enables individuals to define themselves as workers and to be seen that way by their families and employers" (p.15). Lytel (1978) stated that clients who place the locus of control outside themselves may be prone to explain their lack of work adjustment in terms of external factors rather than accepting responsibility for their own behaviour. The question of whether this holds true for mental health consumers remains unanswered.

Research examining empowerment or components of empowerment and its effects on employment for mental health consumers is extremely limited. A qualitative study examining influences on the process of work integration for mental health consumers (Kirsh, 1996) identified a critical process in becoming employable as that of establishing an identity separate from that of a person with an illness, and perceiving some control over the effects of the illness itself. However the relationship of other indicators of empowerment to employment is unknown. Earlier discussions pointing to links between consumer involvement and empowerment suggest that meaningful activity and empowerment are interdependent with one another, and this has been supported by research which shows that the stronger a person's sense of control over life, the more frequently he or she is involved in meaningful activities in the
community (Hall & Nelson, 1996). Does it follow, then, that the stronger a person’s sense of empowerment, the more likely he or she is to be engaged in employment opportunities? The relationship between employment and empowerment is brought into question by findings such as these.
Chapter 3: Social Support

Social support is a heterogeneous concept (Cobb, 1976; Cassel, 1976) around which an expansive and varied body of literature has developed. This concept has been, and continues to be studied as an important variable in physical and psychological well-being, particularly in relation to stress, coping, health outcomes and adaptation. Definitional aspects of social support vary, though most frequently the term refers to "helpful functions performed for an individual by significant others such as family members, friends, co-workers, relatives and neighbours" (Thoits, 1985, p. 53). However, other conceptualizations of social support venture into deeper and more complex levels to reflect its multidimensional nature. For example Cobb (1976) and Turner (1983) capture the qualitative and phenomenological aspects of support. Cobb views social support as information leading the subject to believe that he "is cared for and loved,... esteemed and valued and belongs to a network of communication and mutual obligation" (Cobb, 1976, p. 300). Similarly, Turner (1983) emphasized the experiential nature of the concept in his definition: "the clarity or certainty with which the individual experiences being loved, valued, and able to count on others should the need arise" (Turner, 1983, p.110). These definitions capture the benefits of support as well as the subjective experience so critical to its effects. Further elaboration of important dimensions of social support, as discussed in the literature, follows.
Dimensions of Support

Most discussions of social support reflect empirical evidence which confirms the existence of distinct dimensions of the construct. Firstly, functional aspects of support have been analyzed and can be said to include both affectively significant and instrumental ones. Cohen, Mermelstein, Kamarck and Hoberman, (1985) classified these functions into four separate but interacting categories: tangible support, or instrumental aid from others that facilitates fulfilment of ordinary responsibilities such as work, household or child-rearing tasks; appraisal support, or the availability of someone to talk to about one’s problems; self-esteem support, or the availability of a positive comparison when comparing oneself to others; and belonging support, or the availability of others with whom one can participate in activities.

Secondly, structural characteristics of social networks such as the existence, quantity, density and reciprocity of social relationships are considered to be significant (Hirsch, 1980; Pierce, Sarason & Sarason, 1990). An emphasis on these structural issues is theoretically consistent with Berkman and Syme’s (1977) early definition of social support which identified social participation as the key issue, as exemplified, for instance, by marriage, friendships and group membership. Finally, theorists have considered level of satisfaction with type and amount of support offered to be an important component in understanding the impact of social support (Newcomb & Chon, 1989). In fact, Kaplan, Cassell and Gore (1977) defined social support in terms of the degree to which
one’s needs are satisfied through interpersonal interactions. The many layers and components of social support have led to differing perspectives on mechanisms of action and processes by which effects may be realized, as well as methodological issues including instrumentation.

**Subjective versus Objective Support**

One of the controversies surrounding social support research has been whether conceptualizations should focus upon the subjective or objective nature of the concept, that is, perceived versus enacted support. Lieberman (1982) maintained that an individual’s perception of having a sufficient and available social network is more important in reducing stress than whether or not the network is actually used. In fact, it has been found that perceived support is predictive of the frequency of actual supportive interactions (Cutrona, 1986). Studies on depression and social support lend further support to this argument. Stronger relationships between perceptions of social support and course of major depression have been found than those between objective assessments made by clinicians and course of illness (Brugha et al., 1990; Hooley, Orley, & Teasdale, 1986; Keitner et al., 1995). A possible explanation for the predictive value of perception of support may be that effects of social support are cognitively mediated, and that support directly influences one’s primary appraisal of stressfulness (Cohen et al., 1985), as well as affecting secondary appraisal mechanisms. That is, social support
influences other coping resources such as sense of control or competence (Schreurs & de Ridder, 1997).

Perspectives emphasizing subjectivity have inevitably led to discussions regarding overlap of effects of social support with other personality variables. Individual personality traits which have been studied as potential moderators of perceived availability and effects of support include introversion/extroversion (Monroe & Steiner, 1986), neuroticism (Bolger & Eckenrode, 1991), hardiness (Blaney & Ganellen, 1990), locus of control (VanderZee, Buunk & Sanderman, 1997), optimism (Sumi, 1997) and interpersonal skills (Brugha, 1995). Findings have been complex and inconclusive regarding the degree to which intra-individual and extra-individual factors contribute to perceptions of social support; agreement exists only in the notion that social support appears to be influenced by a variety of environmental and constitutional factors.

Social Support and Well-Being: Process Models

A significant body of literature overwhelmingly supports positive relationships between social support and health. Studies show higher levels of subjective well-being in individuals who report greater social support than in those who report less social support (Cohen & Wills, 1985; Ganster & Victor, 1988). Social support has been shown to have an inverse relationship to such illnesses as depression, anxiety, and somatic complaints (Sumi, 1997). Relationships between social support, coping and adaptation
to chronic disease have been investigated in studies of patients with chronic pain (Turner, Clancy & Vitaliano, 1987), cancer (Ell, Mantell, Hamovitch & Nishimoto, 1989), and diabetes (Kvam & Lyons, 1991) amongst others, and in general, have shown that social support contributes to more adaptive coping strategies. However, there is a lack of consensus on the mechanism of action; that is, how social support contributes to these positive outcomes. Empirical evidence supports two main models. First, the buffer or vulnerability model maintains that social support reduces or "buffers" the adverse effects of stressors or negative life events (Cassel, 1976; Cobb, 1976; Cohen & Wills, 1985; Kaplan, Cassell & Gore, 1977). Within this model support is seen to have little impact upon health outcomes when stressful circumstances are absent. It is therefore applicable to those individuals experiencing significant levels of stress or stressful life events. This buffering function of social support has been confirmed in a number of studies (Brown, Bhrolchain & Harris, 1975; Cassel, 1976; Cobb, 1976; Caplan, 1974; Dean & Lin, 1977). Second, the main effects model maintains that social support preserves or enhances health regardless of the degree of stress experienced by the individual. Supporters of this model have argued that changes in support are in and of themselves stressors, and therefore affect well-being, regardless of the occurrence of other stressful life events (Thoits, 1986). Studies support this view as well. Many report inverse relationships between measures of support and psychological disturbance in the absence of stress-buffering
functions (Andrews, Tennant, Hewson & Vaillant, 1978; Williams, Ware & Donald, 1981).

In their review of the literature, Cohen and Wills (1985) found that studies focusing on structural aspects of support (such as frequency of contacts) supported the main effect model. They hypothesized that the existence of social structures, or social integration, is associated with a perceived sense of security, stability and self worth, benefits which are reaped independent of the degree of life stress. Conversely, studies of functional components of support (or type of support available) appeared to reflect the buffer hypothesis. This, they explained, reflects the need for specific support resources in the face of particular life events. However, a comprehensive and clear understanding of conditions under which buffering effects only, main effects only, or effects of both processes are observable has not been reached. Thus, it may be said that social support can have a buffering effect on stressful life events as well as a direct effect on perceived well-being, both of which serve to enhance coping and health outcomes.

Social Support and Mental Health Consumers

In light of the evidence pointing to health promoting functions of social support, particularly its effects on coping and adaptation, it seems important to examine potential applications of social support theory to the health and adaptation of mental health consumers. Studies conducted with persons with mental illnesses
have found that high levels of environmental stress interact with individual variables to increase vulnerability to psychotic episodes or exacerbations of the illness (Birley & Brown, 1970; Hultman, Wieselgren & Ohman, 1997). In addition, coping strategies amongst individuals with schizophrenia have been found to resemble those of persons labelled as depressive or neurotic and differ from "normal" individuals (van den Bosch, Van Asma, Rombouts & Louwerens, 1992). Therefore, a sound rationale exists for examining social support as a buffering mechanism which may minimize the detrimental effects of stressful life events (so pervasive in living with a mental illness) as well as a possible means of modifying coping processes to enhance adjustment for mental health consumers.

Research in area of social support and psychiatric illness reveals associations between social support, mental illness, and adaptation. Studies have clearly demonstrated the positive impact of supportive persons on community integration outcomes (Cannady, 1982; Hatfield, 1979; Schoenfeld, Halvey, Hemley van der Velden & Ruhf, 1986; Thompson & Doll, 1982). Studies on depression have shown that social support is a significant factor affecting course and outcome of the illness. For example, Lara, Leader, and Klein (1997) found that social support significantly predicted both severity of depression and recovery from depression after controlling for several confounding clinical variables. Similarly, Hays et al. (1997) examined correlates of chronic depression and found that social support was more relevant to chronicity than were other variables such as severity of illness or family history.
The characteristics of social networks of persons with severe mental illnesses have been investigated and described by a number of researchers (Cutler & Tatum, 1983; Morin & Seidman, 1986), but there is a lack of clarity on network dimensions which are associated with specific findings. Hall and Nelson (1996) hypothesized that a mediational model, which views social networks as having an indirect effect on adaptation (via social support), may provide a template for viewing the interactions between social support, social networks and well-being in psychiatric consumers. Effects of network characteristics can be found in early work by Cohen and Sokolovsky (1978) which reported negative correlations between the size of one’s social network and the degree of pathology. In a prospective longitudinal study, Erikson, Beiser, Iacono, Fleming and Lin (1989) showed a positive association between non-family social resources and good outcome for first-episode patients with schizophrenia or affective psychosis. Network enhancement strategies described by Thornicroft, Breakey and Primm (1995) resulted in improved aspects of social functioning amongst persons severely disabled by chronic psychotic conditions, though careful interpretation is needed as this was an uncontrolled study with a relatively brief follow-up period. Degree of social integration, or network embeddedness, was explored in recent work by Hultman and colleagues (1997) who found a higher relapse rate amongst people with schizophrenia who were content with low social integration as compared to those who wanted more. Furthermore, support for the buffering hypothesis was offered in their finding.
that time between stressful life event and relapse was significantly extended among those with high availability of attachment.

In most of these studies, indicators of outcome have focused upon components of mental illness. However, in recognition of the increased emphasis on consumer perspectives, several studies using measures of subjective well-being as an outcome have also been conducted. These too have found frequency of support to be directly associated with consumer well-being and community integration (Clinton, Lunney, Edwards, Weir & Barr, 1998; Earls & Nelson, 1988; Kennedy, 1989; Moxley, 1988; Nelson, Hall, Squire & Walsh-Bowers, 1992). Indeed, the assertion made by Gottlieb and Coppard (1987) appears to be a valid one, that is "the quality of the patient's life in the community, and ultimately the length of community tenure, hinge on the support and care rendered by the patient's social world" (p. 129).

Social Support and Productivity

Some research has been done on social support and employment amongst non-clinical populations and has demonstrated a relationship between unemployment and poorer quality of social support. In a study of over 18,000 employed and unemployed adults, it was found that the unemployed group had approximately double the percentage of persons reporting lack of support, and almost three times the percentage reporting no sources of support (Roberts, Pearson, Madeley, Hanford, & Magowan, 1996). This group also
reported poorer perceived physical and mental health, and were twice as likely to report poor mental health than physical health. The researchers speculated that differences in the quality of social support was a variable which could explain morbidity, especially related to mental health, amongst the unemployed, but the question of whether more positive social support would make a difference in employment status and health outcomes is unknown.

The personal and social challenges of living with a mental illness often result in disruption of role-related activities, including employment. The question of whether the main effects and buffering properties of social support exert influence on role fulfillment capacity is one in need of further exploration. Social interaction may provide the main effects, or the protective factors such as stability, security and sense of self-worth, needed for maintaining personal roles as well as gauging appropriate social conduct. As stated by Thoits (1985), "role relationships can be beneficial by providing a set of identities, as sources of positive self-evaluation, and as the bases for a sense of control or mastery" (p. 57). Furthermore the buffering mechanism may serve to protect mental health consumers from adverse effects of the stress of living with a psychiatric illness, thereby enabling the trajectory to continue on a more positive and productive course.

Research on support, productivity and mental health consumers has been very limited and has concentrated on current models of work integration such as supported employment. Clearly, approaches which incorporate follow-along support from vocational or mental
health programs demonstrate improved employment outcomes for working individuals than more traditional approaches to vocational rehabilitation (Anthony & Blanch, 1987; Pedlar, Lord & Van Loon, 1990). However, there is limited information about the effects of social support for persons who choose not to engage in such programs, as well as dimensions of support which may be most important in fulfilling productive roles, particularly employment, in a satisfying way. Hall and Nelson (1996) studied the relationship between social support and the adaptation of consumers and found that more positive social support correlated with positive affect and greater involvement in meaningful activities. This finding is an important one, as it focuses not on mere involvement but meaningfulness of such participation. The importance of social support in maintaining employment has also been emphasized in two qualitative studies of working consumers. Kirsh (1996) investigated consumers who were competitively employed and found emotional support to be particularly important, with references to family and peer group, and instrumental and informational support being highly valued. Similarly, Strong (1998) found that amongst persons with psychiatric disabilities working at an affirmative business, the work process was enhanced by external relationships which allowed them to "feel healthier, experience pleasure and see new possibilities and opportunities" (p.37), suggesting that both the benefits of the main effects and the buffering hypothesis may have been reaped. It is reasonable to believe that adequate levels of support are facilitative, if not
necessary for mobilization of internal resources required for the assumption of new or interrupted roles such as "worker". However, this relationship has not been sufficiently investigated in the mental health population and many questions regarding the nature and impact of support on employment outcomes remain unanswered.
Chapter 4: Organizational Culture, Climate and Person-Environment Fit

A growing concern with physical, psychological and organizational environments and their impact on behaviour has resulted in a substantial body of literature on organizational culture and climate. Numerous researchers have attempted to identify cultural characteristics of the workplace that contribute to productivity and job satisfaction. Attention is currently being drawn to "healthy workplaces" and their components, and writings on the changing face of work in our global economy abound. Clearly, the effectiveness of work environments in meeting the needs of organizations and individuals within the general population is of primary concern within our society today. However, few, if any, researchers have attempted to analyze contextual aspects of workplaces as they impact upon persons with mental health problems. This study focuses attention on organizational culture and climate, and their impact on mental health consumers, in order to increase understanding of positive work environments as perceived by consumers. Furthermore, it addresses the effects of degree of congruence between persons and their work environments through analysis of the concept of person-environment fit. This inquiry into organizational culture and climate, and person-environment fit is necessary because of its potential to improve the organization-employee relationship, and to ultimately increase opportunities for successful, satisfying employment for mental health consumers.
Organizational Culture

Despite common themes and overlap in definition and conceptualization, inconsistency and debate characterize much of the writing on organizational culture. Schein (1984) emphasized that the concept of organizational culture is a deep phenomenon which is complex and difficult to understand. Nevertheless, efforts to do so are worthwhile as a means of illuminating individual psychological behaviour, what goes on in small groups and how organizations work. Pettigrew (1983) explained that in order for people to function within any given setting they must have a continuing sense of their reality before acting upon it:

...In the pursuit of our everyday tasks and objectives, it is all too easy to forget the less rational and instrumental, the more expressive social tissue around us that gives those tasks meaning. Culture is a system of publicly and collectively accepted meanings operating for a given group, at a given time. This system of terms, forms, categories and images interprets a people's own situation to themselves (p. 93).

Workplace cultures have been shown to affect workers' commitment to and identification with the group and organization, as well as their sense of involvement with their work assignments (Etzioni, 1961; Wiener & Vardi, 1991). The socialization of new members is facilitated by work group cultures (Louis, 1980). In fact, Schein (1984) pointed out that ultimately, what makes it possible for people to function comfortably with each other and to concentrate on their primary task is consensus on the cultural assumptions. It follows then, that attention to work cultures is warranted in examining issues of work integration for mental health consumers, as a means of identifying the process and degree to
which comfort, commitment, and social integration at the workplace develop. As stated by Hagner and Dileo (1993), "the better we understand the dynamics of workplace cultures, the better we will be able to assist employees, including those with disabilities, to become socially included at work. The clues to inclusion are found in understanding the culture" (p.30).

Variations in defining organizational culture are numerous. Schein (1984) viewed culture as "basic assumptions and beliefs that are shared by members of an organization, that operate unconsciously and that define in a basic taken-for-granted fashion an organization's view of itself and its environment" (p. 6). He viewed norms, values, rituals and climate as manifestations of culture. Similarly, Louis (1985) defined culture as a commonly held set of understandings for organizing action. Cooke and Rousseau (1988) saw culture as normative beliefs shared by members of a social unit. Pettigrew (1983) regarded organizational culture as a source of a family of concepts including symbol, language, ideology, belief, ritual, and myth. In other words, culture refers to "the broader pattern of an organization's mores, values and beliefs" (Schneider, Gunnarson & Niles-Jolly, 1994, p. 18).

Organizational Climate

Numerous definitions have been offered to clarify the concept of organizational climate (Argyris, 1958; Guion, 1974, Howe, 1977) but here too, a lack of agreement on the specific dimensions of the concept is evident. Hellreigel and Slocum (1974) reviewed the
relevant literature and defined organizational climate as

a set of attributes which can be perceived about a particular organization and/or its subsystems, and that may be induced from the way that organization and/or its subsystems deal with their members and environment (p.256).

This definition places emphasis on perceptions of individuals as reflections of organizational climate and, as noted by Wilgosh (1990), frames organizational climate as a psychosocial concept, "different from an organization’s structure or leadership" (p.10). Field and Abelson (1982) further emphasize the centrality of perception in defining and studying organizational climate, stating "it is proposed that climate is an abstract perception of the individual and may occur at an organizational, group and/or individual level" (p. 182). James, Joyce and Slocum (1988) also support the conceptualization of organizational climate as made up of perceptions. They stated:

attributing meaning to environmental stimuli is a product of cognitive information processing, and it is individuals, not organizations, that cognize. The basic unit of theory for meaning is the individual.(p. 130).

It follows, then, that perceptions are the appropriate unit of measure, and it is this premise that should direct investigation of organizational climate at the individual level with consumers of mental health services.

Research on organizational climate points to its potential to guide behaviours critical to employment: job performance, productivity and "citizenship behaviours" (Kopelman, Brief & Guzzo, 1990; Schneider & Bowen, 1985; Schneider, Parkington & Buxton, 1980). Studies have shown that climate is tied causally to
promotion rate, productivity, turnover rates, and salary progression (James & Jones, 1976). Considerable evidence indicates that dimensions of climate are also associated with job satisfaction (Friedlander & Margulies, 1969; Pritchard & Karasick, 1973) and directly affect motivation (Anderson, 1982).

Although the interaction of organizational climate and employee behaviours, satisfaction and tenure have been studied in the general population, few such studies exist for persons with special needs, specifically mental health consumers. In view of the impact and implications of the climate of the workplace, it is important to consider the question of whether particular dimensions of workplace climate are more valued and facilitative of adaptive work behaviours for this group.

Organizational Culture and Climate: Concepts Intertwined

The two concepts, organizational culture and climate, co-exist and at times converge in definitional and operational terms. Specific differences have been documented and focus on climate as the perception of the individual as opposed to culture as a deeply rooted set of organizational values. As stated by Rousseau (1990): "climate as a product of individual psychological processes (and the individual’s potentially idiosyncratic experience of the organization) and culture as a unit-level phenomenon that is derived from social interaction are distinct constructs" (p. 159). Yet most researchers agree that although they may be distinct from one another, the two concepts are very similar (Denison, 1996;
Reichers & Schneider, 1990). After a lengthy comparison of the two concepts, Denison (1996) concluded that "the culture and climate literature actually addresses a common phenomenon: the creation and influence of social contexts in organizations" (p. 646) and that the two research traditions involved should be viewed as differences in interpretation rather than differences in the phenomenon (p. 645).

Differences in interpretation of the terms culture and climate bring to question the research methods that most appropriately bear on them. Organizational researchers have documented observable phenomena, gathered information from published sources and conducted personal interviews (for example Deal & Kennedy, 1982; Hickman & Silva, 1988). Some experts in the field of organizational behaviour believe that culture is transmitted mainly through employees sharing their interpretations of events or through storytelling (Schneider, Gunnarson & Niles Jolly, 1994) suggesting qualitative methods as the primary means of investigation. Others have tried to uncover values and beliefs through survey questionnaires and scales designed to measure organizational culture in a quantitative way (Cooke & Rousseau, 1988). Thomas, Ward, Chorba and Kumiega (1990) encouraged a multi-method approach which elicits both qualitative and quantitative data as this would be seen to be complementary, allowing exploration of cognitions, symbols and interactions as well as internal variables which affect outcomes.
**Person-Environment Fit**

Examination of both the culture and climate of the work environment allows not only an in-depth understanding of workplace issues affecting work behaviours, but how well individuals fit into organizational contexts and vice versa. Research and theory linking characteristics of individuals and situational aspects illuminates the relationship of person-environment fit to individual outcomes. Wilkins and Ouchi (1983) proposed that organizations have cultures that hold varying degrees of attractiveness for different types of individuals. It may be the case that individuals are attracted to organizations they perceive to have values consistent with their own. Similarly, organizations may recruit individuals who share their values (Schneider, 1987).

Research suggests that person-environment fit increases commitment, satisfaction and performance (O'Reilly, Chatman & Caldwell, 1991; Smith & Tziner, 1998). The literature states that congruence between characteristics of the work and individuals' personalities are associated with positive affect (Mount & Muchinsky, 1978; Spokane, 1985) and a high probability of continued employment (Meir & Hasson, 1982). Job satisfaction has also been attributed to a "suitability of the individual to the environment and vice versa" (Lofquist & Dawis, 1969, p.45). Gustafson and Mumford (1995) used cluster analysis to examine clusters of types of people and environments which they then related to outcome measures such as satisfaction, performance and withdrawal. Differences in types of individuals and outcomes within particular
environments pointed to the importance of fit. A study by O’Reilly, Chatman and Caldwell (1991) found person-organization fit to be a significant predictor of normative commitment, job satisfaction, and intentions to leave, independent of age, gender and tenure. Studies have shown that high person-environment fit increases the likelihood that extra-role behaviours will occur and that individuals will feel more comfortable and competent in organizations that have similar values (Chatman, 1989; Morse, 1975). If it is true that "congruency between an individual’s values and those of an organization are at the crux of person-culture fit" as stated by O’Reilly, Chatman and Caldwell (1991, p. 492) then a thorough exploration of these values is warranted.

Organizational Culture/Climate and Special Populations

Research on components of organizational culture/climate as they impact employment of special populations is limited but useful in generating questions and applications to the mental health population. Studies linking organizational culture with gendered experience have uncovered how behavioural expectations for women can be rooted in assumptions of the work culture (Cassell & Walsh, 1997) and have illustrated ways in which cultural environments prevent women from "flourishing" (Cockburn, 1991). Research into organizational culture and persons with disabilities further emphasizes the importance of culture in work integration. In their study of positive workplaces for persons with disabilities, Ochocka, Roth, Lord and MacGillivary (1994) found that successful
employment was largely determined by the quality of fit between the individual and the workplace culture and maintained that integration for people with disabilities is enhanced by an understanding of culture. Similarly, Hagner and DiLeo (1993) emphasized the importance of culture in "helping people with severe disabilities to achieve quality employment outcomes as well as for employers wishing to better utilize diverse and traditionally untapped sources of labour" (p. 29).

Research suggests that productive and meaningful employment is achievable for persons with disabilities under conditions of well-matched jobs, sufficient skill development and support services which co-exist with employment (Church & Pakula, 1984; Kiernan & Stark, 1986; Mchugo, Drake & Becker, 1998). A fair amount of literature on workplace accommodations exists, with a focus on physical or structural accommodations. However, as emphasized by King (1993) in his article advising employers on how to manage workplaces to include employees with disabilities, altering the physical environment is but a small part of inclusion; fostering a corporate culture that fully welcomes workers into the life of an organization is truly what is needed. A qualitative study by Boyle (1994) exploring perceptions of physically disabled adults re-entering mainstream employment emphasizes this point: it revealed that the barriers encountered were typically the result of a social environment "which stereotyped them as damaged goods or second class citizens unable to make competent decisions or cost effectively perform most job duties" (p.429). In fact, Moseley
(1988) reflected that one of the major problems confronting persons with disabilities in the workplace is that other, non-disabled workers may not know how to interact with them. Attitudinal issues including concerns around low productivity, increased insurance costs and high absenteeism (Freedman & Keller, 1981) contribute to variable levels of receptivity of persons with disabilities in the workplace. In an attempt to elucidate and deal with such issues, King (1993) developed and documented experiential exercises designed to break down attitudinal barriers and create a culture of inclusion.

A limited amount of research with employers and persons with disabilities has pointed to workplace variables affecting employment. A study of conditions which enable or impede the performance of work by persons with multiple sclerosis pointed to human support (assistance with tasks, emotional support), health promotion (intermittent rest periods, absence of stress), and person-environment interaction (organization of the physical environment, self-pacing), as elements of the workplace which contributed to success (Gulick, Yam & Touw, 1989). Findings regarding the role of the supervisor in adjustment to work with a disabling condition have highlighted the importance of treating workers fairly, including them in decision-making and utilizing workers' skills (Gates, 1993). Wilgosh (1990) identified a supportive co-worker climate as a factor most critical to developing "survival" skills in her exploration of organizational climate and workers with mental disabilities. However, the question
of what support actually consists of and how it may be enhanced is not addressed.

**Organizational Culture/Climate and Mental Health Consumers**

Little research has been done on organizational culture/climate and mental health consumers, and the work that does exist is largely speculative in nature. Nevertheless, a review of the literature in the area of workplace characteristics and mental health consumers is warranted.

Not unlike workplaces for other persons, desirable work sites for persons with mental health problems have been described as those that attend to employees' needs and that celebrate diversity (Akabas, 1994). Influential components of the workplace have included both structural aspects such as proximity to home and potential for flexible work schedules, as well as psychosocial characteristics including communication patterns and trust (Kirsh, 1996). Type of disability has been found to be a potential variable intersecting with components of organizational culture, as attitudinal barriers have been found to be deeply ingrained in the culture and climate of organizations. Negative reactions among employers to hiring people with mental illnesses have been documented. For example, Drehmer (1985) found that people with mental illness were significantly less likely to be placed in a job than individuals with paraplegia or non-disabled clients despite identical job qualifications and work histories. In their study of workplaces and persons with disabilities, Ochocka et al. (1994)
found that people with psychiatric disabilities tended to be particularly isolated from the culture, and they further noted that accommodations required for people with developmental or psychiatric disabilities involve attitudinal change within the culture. Such findings carry implications for education and policy: to this end, researchers and practitioners are promoting the inclusion of employers and co-workers in climate and culture change. Akabas (1994), for example, suggested the use of psychoeducational strategies aimed at creating environments which compensate for a functional disability. Cook and Pickett (1995) maintained that both employers and coworkers should be recipients of vocational services along with their disabled coworker. Work cultures which have been responsive to current legislation mandating reasonable accommodation have been examined and have revealed positive findings. In a study of 231 worksite accommodations for workers with serious mental illness, Fabian, Waterworth and Ripke (1993) found that accommodations to the workplace significantly affected employment tenure: the most frequently identified accommodation was orientation and training of supervisors to provide necessary assistance, followed by modifications of the non-physical work environment and modifications of work hours and schedules. However, as noted by MacDonald-Wilson (1997), there are still unanswered questions about what reasonable workplace accommodations for people with psychiatric disabilities are and how they are developed.

In summary, it may be stated that the significance of
organizational culture and climate - of values, practices, beliefs and worker perceptions - are critical to full inclusion and integration of any person entering a work situation. Although components of organizational culture and climate have been widely researched with respect to organizations and workers in general, there is a paucity of information regarding effects of culture on special needs groups, particularly consumers of mental health services.
Chapter 5: Methods

Methodology

This study utilized a mixed-method design to understand the experience of work integration for mental health consumers and to identify factors influencing its process and outcomes. The use of mixed-method design is becoming widely accepted, and such approaches have moved from a position of conflict between qualitative and quantitative researchers to one of compatibility and cooperation. As stated by Smith and Heshusius (1986), "the demand that an inquirer be 'either/or' has been replaced by the injunction to employ both approaches in combination or to draw on both styles at appropriate times and in appropriate amounts" (p. 4). Increased recognition of the need for a full understanding of research problems from a variety of perspectives has given rise to writings by numerous researchers about the importance of adopting a "pluralist attitude" (Howe, 1988, p. 11) in conceptualizing research questions (see, for example, Howe, 1988; Kidder & Fine, 1987; Laurie & Sullivan, 1991; McLaughlin, 1991; Smith & Heshusius, 1986).

Mixed-method designs have been identified as fulfilling a number of functions. A classification system developed by Greene, Caracelli and Graham (1989) (cited in Caracelli & Greene, 1993), based on an analysis of 57 evaluation studies, described five main purposes of mixed method designs: 1) triangulation, which seeks corroboration and correspondence of results across different methods; 2) complementarity, indicated when the two methods are
used to measure overlapping but distinct facets of the phenomenon under investigation; 3) development, referring to the sequential use of method types so that one method may help develop or inform the other method; 4) initiation, designs which provoke the reformulation of questions from one method type with questions or results from the contrasting method type; and 5) expansion, the use of mixed methods to uncover fresh insights or new perspectives as the breadth and range of inquiry are extended by using different methods for different inquiry components. This study employs a mixed method design to achieve three of the above functions: triangulation, complementarity, and expansion.

Triangulation is described by Denzin (1978) as a vehicle for cross validation when two or more distinct methods are found to be congruent and yield comparable data. However, Mathison (1988) maintained that inconsistency or even contradiction in outcome is as frequent and acceptable as consistent results:

...when multiple sources, methods, and so on are employed we frequently are faced with a range of perspectives or data that do not confirm a single proposition about a social phenomenon. Rather, the evidence presents alternative propositions containing inconsistencies and ambiguities...we use not only convergent findings but also inconsistent and contradictory findings in our efforts to understand the social phenomena we study (p. 15).

The true value of triangulation, according to Mathison (1988), Jick (1983), and others is its ability to capture a more complete, holistic and contextual portrayal of the unit under study. In this study of factors associated with work integration, it was not only important to study variables significant to positive outcomes, but
also to examine contextual components of these variables and their integration and relationship to lived experience. Furthermore, as the phenomena under investigation included the interactions between persons and organizations it was particularly important to be inclusive of different methods. Jick (1983) strongly advised organizational researchers to make use of multiple methods to examine dimensions of organizations.

Complementarity draws on mixed methodology, with each method carrying out a different but complementary function. Mark and Shotland (1987) suggested that the complementary purposes model may draw on different methods for alternative tasks. This is the case in utilizing mixed methods in the study of factors associated with work integration for mental health consumers. Quantitative methods were designed to reveal relationships between variables and vocational outcomes, while qualitative methods were utilized to explore the process of work integration and adjustment, including dynamic interactions between people and organizations. Another instance of complementarity is described by Mark and Shotland (1987) as "enhancing interpretability", that is, qualitative results may be used to make statistical findings more understandable and better communicated, or vice-versa. Again, this characteristic may be applied to the use of mixed method design in this study, as, significant variables (for example, organizational climate and culture) were given substance and meaning through narrative and conversely, descriptive qualitative material resonated with quantitative findings.
Expansion, defined by Caracelli and Greene (1993) as the extension of breadth and range of inquiry, was achieved in this study through the use of a quantitative-qualitative design. Although Caracelli and Greene do not include increased depth of understanding as a component of expansion, it too, was an intended result of mixed method design. While quantitative approaches shed light on important factors contributing to employment, qualitative data increased understanding of the meaning of work to mental health consumers and examined the social context in which the challenges of work must be met. As recommended by Fielding and Fielding (1986), through the careful and purposeful combination of different methods breadth and depth are added to the analysis.

Bryman (1988) explored three main ways in which researchers using qualitative and quantitative approaches have combined them: qualitative work as a facilitator of quantitative work; quantitative work as a facilitator of qualitative work; both approaches are given equal emphasis. In the same light, Brannen (1992) discussed sequencing and weighting of methods in multi-method studies, advising that methods may be conducted simultaneously or consecutively and that linkages between methods may occur at many different stages of the study.

In the current study the quantitative and qualitative components of the research proceeded simultaneously alongside one another. Consistent with Brannen's description and exemplification of studies which assign equal weighting to quantitative and qualitative methods, this study is distinguished by the fact that
"both types of data figure roughly equally in terms of resources allocated to them and both play an equal part in the analysis and writing up" (Brannen, 1992, p. 29). Linkages between data sets occurred throughout the write-up and interpretation of results.

In summary, the use of mixed methods in this study served to validate findings, increase understanding of issues related to work integration through examination of multiple perspectives, and broaden and deepen the scope of inquiry. As stated by Caracelli and Greene (1993), "a mixed method framework highlights its integrative potential and underscores its power to spiral iteratively around the different data sets, adding depth of understanding with each cycle" (p. 202).

Participants

Participants in this study were consumers of mental health services, previously hospitalized for mental illness on at least one occasion, who had gone through the process of work integration; that is, they looked for and secured employment subsequent to their illness. Thirty-six participants were recruited (N=36) and placed into one of two groups: 1) those who were working in mainstream employment and had maintained their employment for a period of at least six months (n=17), and 2) those who had left their employment in integrated settings within the six-month period prior to recruitment (either because they were asked to leave or because they chose to leave: n=19). The groups were highly similar in demographic characteristics. The employed group was 59% male and
41% female with a mean age of 42.4 years and a mean of 6.4 hospitalizations. Fifty-three percent of the employed group reported a diagnosis of affective disorder, 35% reported schizophrenia or schizoaffective disorder and 12% reported anxiety disorders. The unemployed group was 47% male and 53% female with a mean age of 42.2 years and a mean of seven hospitalizations. In this unemployed group, 67% reported a diagnosis of affective disorder, 22% had schizophrenia or schizoaffective disorder, and 11% had anxiety disorders. All participants had experienced significant disruption and turmoil in the social and vocational areas of their lives as a result of their mental illnesses.

Procedures

The study underwent ethics review at the Ontario Institute for Studies in Education at the University of Toronto and was granted approval. Methods of participant recruitment consisted of contacting consumer groups and programs whose mandates included vocational rehabilitation, as well as advertising the study in a consumer newsletter. Coordinators or contact persons at these consumer groups and vocational programs informed their membership or clients of the study and interested participants contacted the investigator by phone to inquire about participation. At this point they were given information about the study’s purpose, procedures, time requirements and criteria for participation. If the person qualified for the study and decided to participate in it, a meeting was arranged in which the study’s goals and procedures were
reviewed in detail, a letter of information (Appendix I) was discussed and given to the participant, and a consent form (Appendix II) was signed by the participant. Participants were asked to complete four questionnaires (one of which was demographic) and a card-ranking task. They were also asked to participate in a tape-recorded interview. Confidentiality was assured both verbally and in writing through the letter of information and consent form. Participants were offered an honorarium of $20.00 for their participation.

**Instruments**

All instruments used in the study were pilot tested on two consumers and two non-consumers. This process resulted in changes to the wording of some items on the Workplace Climate Questionnaire (WCQ) and omission of a few items on the Organizational Culture Profile (OCP). Furthermore, administration procedures such as sequencing of tasks and use of audio equipment were enhanced through pilot testing, thereby improving efficiency and the nature of the research environment. In general, both quantitative and qualitative data were collected within a single session, with quantitative data preceeding qualitative data collection. Breaks were offered to participants as needed.

**Quantitative Data Collection**

Five instruments were used for quantitative data collection: a demographic questionnaire (Appendix III); the Interpersonal
Support Evaluation List (ISEL); the Empowerment Scale (Appendix IV); the Workplace Climate Questionnaire (WCQ; Appendix V); and the Organizational Culture Profile (OCP; Appendix VI). Two of these instruments, the demographic questionnaire and WCQ, were developed by the investigator, and the other three instruments (ISEL, Empowerment Scale and OCP) were extracted from the social science, psychiatric and management literature, respectively. A review of the instruments which address the variables of this study, that is, the ISEL, Empowerment Scale, WCQ and OCP, follows.

**Interpersonal Support Evaluation List (ISEL).** (Cohen, Mermelstein, Kamarck & Hoberman, 1985). The ISEL consists of 40 statements concerning the perceived availability of social support which participants are asked to label as "True" or "False". Half the items are positive statements (for example, "there are several different people with whom I enjoy spending time") and half are negative statements ("No one I know would throw a birthday party for me"), therefore the items are counterbalanced for desirability. The ISEL assesses the perceived availability of four functions of social support and accordingly, items are categorized into one of four subscales: tangible, appraisal, self esteem and belonging. The "tangible" subscale measures perceived availability of material aid; the "appraisal" subscale addresses the perceived availability of someone to talk to about one's problems; the "self-esteem" subscale deals with the perceived availability of a positive comparison when comparing one's self with others; and the
"belonging" subscale measures perceived availability of people one can do things with (Cohen, Mermelstein, Kamarck & Hoberman, 1985). The ISEL is scored by counting the number of responses indicating support, providing a maximum score of 40.

Initial psychometric testing of the ISEL was carried out with a group of individuals in a smoking cessation program (Mermelstein, Cohen & Lichtenstein, 1983, as cited in Cohen, Mermelstein, Kamarck, & Hoberman, 1985). Mean scores across three measurement periods for respondents ranged from 32.9 to 34.4 with standard deviations ranging from 4.96 to 5.98. Internal reliability (alpha coefficient) of the ISEL in the smoking cessation study was .90. A later study examining the association between social support and course of depression yielded an alpha coefficient of .94 (Lara, Leader, & Klein, 1997). Similarly, the alpha coefficient in the current study is .9436. Adequate test-retest reliabilities have been found for the ISEL in several samples. Data also suggest reasonable stability across time: after six months test-retest correlations with individuals in the smoking cessation program were .74 (Cohen, Mermelstein, Kamarck, & Hoberman, 1985). Validity of the ISEL was demonstrated through correlations between it and other social support measures: correlation with the Moos Family Environment Scale was .30 and correlation with the Partner Adjustment Scale was .31 (Cohen et al., 1985).

The Empowerment Scale. (Rogers, Chamberlin, Ellison & Crean, 1997). The Empowerment Scale was selected for use in this study
because of its focus on dimensions of empowerment as they relate to persons with mental illness. In fact, this instrument is a consumer-constructed scale designed to measure the construct of personal empowerment as defined by consumers of mental health services themselves. Many other scales relating to empowerment and control were explored, but most of these were either highly clinical in nature, or conveyed a message of researcher-as-expert, a contradiction of the very essence of empowerment. The Empowerment Scale was preferred, primarily because of its consistency in language and philosophy with the experiences of mental health consumers.

The Empowerment Scale consists of 28 brief statements which are rated on a 4-point scale (strongly agree, agree, disagree, strongly disagree). More than half the items are worded in a positive way (for example, "I see myself as a capable person") and the remaining items are negatively worded ("getting angry about something never helps"). Scoring is reversed for negative items and the items are then summed and averaged to arrive at an overall empowerment score out of 4.

The scale was tested on 271 members of six self-help groups in six states in the United States. The mean was 2.94, with a standard deviation of .32 (range, 1.82 to 3.79). Mean scores at the six sites ranged from 2.75 to 3.02. Factor analyses used to identify the underlying dimensions of empowerment revealed five factors which are consistent with the theoretical literature on empowerment: 1) self-efficacy-self-esteem, 2) power-powerlessness,
3) community activism, 4) righteous anger, and 5) optimism-control over the future. To test validity, the Empowerment Scale was administered to two comparison groups. One group consisted of 56 patients hospitalized at a state facility, and the other of 200 college students. In the former group, the mean score was 2.29 (S.D.=.24) and in the latter group it was 3.16 (S.D.=.24). The investigators concluded that these results suggest that the scale is able to discriminate among groups of respondents whose feelings of empowerment differ from one another (Rogers, Chamberlin, et al., 1997). Cronbach’s alpha in Rogers, Chamberlin, et al. study suggested a high degree of internal consistency (alpha = .86, N=261). Similarly, Cronbach’s alpha in this study revealed an alpha level of .87 (N=36), again suggesting a high degree of internal consistency.

Workplace Climate Questionnaire (WCQ). The Workplace Climate Questionnaire was developed by the investigator, drawing on theoretical considerations gleaned from the literature. Twenty-five phrases describing various aspects of the social and structural work environment are presented (e.g., "I receive help in solving problems at work"; "I am able to adjust my working hours when needed") and participants are asked to rate each statement on a 5-point scale: disagree, somewhat disagree, neither agree nor disagree, somewhat agree or agree. Each item may then be assigned a score of 1 to 5, yielding a maximum score of 125. The questionnaire was pilot-tested on two consumers and two non-
consumers and modifications to the order and wording of items were made. Cronbach's alpha suggested a high degree of internal consistency (alpha = .903). Results of an exploratory factor analysis using a principal components analysis and a varimax rotation suggested a somewhat satisfactory factor solution, although a simple structure was not attained, as some variables loaded onto more than one factor. Five factors were extracted, accounting for 62 percent of the variance in scores. Furthermore, conceptual clarity exists in the dimensions offered to workplace climate through these five factors: 1) the psychosocial work environment (communication, respect), 2) the people at work (supervisor, coworkers), 3) control and empowerment (decision-making, advancement), 4) structural issues (benefits, compensation), and 5) ability to do the work itself (training, quality). Table 1 shows the items that loaded onto each factor.

The Organizational Culture Profile (OCP). (O'Reilly, Chatman & Caldwell, 1988). The Organizational Culture Profile was developed to measure person-environment fit and has been used in a number of organizations including accounting firms, government agencies and MBA schools. The instrument contains a set of value statements that can be used to assess the extent to which certain values characterize an organization and an individual's preference for
these values. The assessment uses a Q-sort procedure whereby participants are asked to sort the items into nine categories, ranging from, firstly, most to least desirable and secondly, from most to least characteristic. Distribution is forced and symmetrical as participants are instructed to put a specified number of statements into each category. Fewer items are required at the extremes than in the central, more neutral categories, and categories on either side of the central one are mirror images of one another in terms of the numbers of statements included. Person-environment fit is calculated by correlating the profile of organizational values with the profile of the individual's preferences (O'Reilly, Chatman & Caldwell, 1991). The instrument, as it exists in the literature, consists of 54 items. However for the purpose of this study this number was reduced to 48. Six statements were eliminated as a result of careful analysis of the language and concepts addressed as well as feedback from pilot testing. (For example, the statements "emphasizing a single culture throughout the organization" and "having a clear guiding philosophy" were removed.) The tool was selected from a number of organizational culture instruments and considered to be appropriate for the population under investigation, as the items, placed on Q-cards, offered a visual and concrete medium which could easily be manipulated and altered during the completion process.

Data to develop and test the OCP were obtained from five separate groups of respondents. In a group of accountants, the person-organization fit correlations ranged from -.36 to .62.
Interrater agreement ranged from .80 to .90 for eight accounting firms and the test-retest reliability (one year) was .73 for sixteen MBA students (Chatman, 1989). A later study which dealt with interviewers' perceptions of person-organization fit used a reduced form of the OCP and examined stability of interviewers' perceptions by calculating test-retest reliability (six months), reporting a mean reliability of .61 (Cable & Judge, 1997). Cable and Judge went on to assess the reliability of the most defining values of organizations and computed a second test-retest reliability using only those values rated as 9, 8, or 7 (very characteristic) and 1, 2, 3 (very uncharacteristic). The mean test-retest reliability was .87, leading the investigators to explain that values seen as defining an organization were more stable than those "neither characteristic nor uncharacteristic" of an organization. Validity was demonstrated by O’Reilly, Chatman and Caldwell (1991) through separate factor analyses of individual and organizational profiles: comparability of the dimensions indicated that the types of cultures individuals desire are equivalent to those offered by organizations. In addition, person-environment fit scores were used to predict satisfaction, commitment, and tenure, leading to the conclusion that "person-organization fit possesses predictive validity and is organizationally useful" (O’Reilly, Chatman & Caldwell, 1991, p.502).

Qualitative Data Collection

Completion of the quantitative assessments was followed by a
semistructured interview which was tape recorded and transcribed. The interview guide (Appendix VII) was developed following a review of literature on employment, mental health and consumerism and the completion and analysis of a pilot study on influences on employment for mental health consumers (Kirsh, 1996). As the combined methodology was selected so that each method would inform the other, the interview focused topics on issues related to the central questions of this study, those being issues of social support, empowerment and organizational climate and culture. However, significant flexibility was offered to pursue related topics or issues which may have been triggered by the question or topic at hand. As suggested by many qualitative researchers, the semi-structured format provided a consistent framework of questions and probes for each interview and, at the same time, allowed flexibility to pursue viewpoints of respondents in depth (Fry & Keith, 1986; Marshall & Rossman, 1989; Patton, 1980). Interviews took place in a location determined by the participant and ranged from approximately 30 to 90 minutes in length.

Data Analysis

Quantitative Data Analysis

The data of the total sample was examined as well as the data of each of the two groups (employed and unemployed) of participants. Chi-square and t-tests were carried out to conduct comparisons on demographic characteristics as well as on each of the variables examined (empowerment, social support, organizational
culture/climate and person-environment fit). Effect sizes were calculated for desired and experienced organizational characteristics examined by the OCP in order to determine differences between the employed and unemployed groups. Correlations were performed between variables and finally, logistic regression analyses were carried out to determine predictors of employment.

Qualitative Data Analysis

The qualitative data set consisted of verbatim typed transcripts which were analyzed, at times, in conjunction with the audiotapes themselves. The text of the interviews was examined primarily through inductive analysis, that is, categories of meaning were derived from the data as opposed to imposing a defined coding system. The data were carefully indexed and analytic categories were created. For the purposes of this study, categories which informed or shed light on the study’s hypotheses and issues under investigation were analyzed further and those categories which did have some relationship to the issues under investigation were amalgamated and/or subdivided to form the central themes and subthemes of the study. This method of inductive analysis has been suggested by many qualitative researchers, for example, Glaser and Strauss (1967), Miles and Huberman (1984), and Strauss (1987).

Linkages between Data Sets

The combined use of quantitative and qualitative methods is,
as has been discussed, a way of increasing breadth, depth and communicability of results. However, despite recommendations by some researchers, actual integration of data sets involving such techniques as data transformation or data merging (Caracelli & Greene, 1993) disregards the epistemology upon which each approach is based. As stated by Brannen (1992), an advocate of mixed methods:

in so far as the use of different research methods is underpinned by different sets of ideas - about the nature of data, theories about the social world and so on - it is inappropriate to integrate data sets produced by different methods. Rather the researcher should seek to relate each set of data to the theory underpinning it and to see in what ways the data sets complement and contradict one another (p. 31).

Accordingly, data analysis in this study respected the boundaries and underlying philosophies of each approach by utilizing separate and different analysis strategies. Comparisons of the quantitative and qualitative data were made on an ongoing basis during analysis as each set of results informed and illuminated the other. As a result, findings which were on the one hand statistically reliable, and on the other allowed a depth of interpretation that would not be possible from the quantitative data alone, were attained.
Chapter 6: Results of Quantitative Analysis

Background Characteristics

The two groups (employed and unemployed) of mental health consumers were similar in demographic characteristics. Table 2 provides descriptive statistics (means, standard deviations, ranges) on the interval data. t-tests indicated that the two groups did not differ significantly on age \[ t(1,34)=.054; p=.957 \] or number of hospitalizations \[ t(1,34)=-.243; p=.809 \].

Table 2 here

Table 3 summarizes data from the categorical demographic variables: gender, education, number of jobs, diagnosis, length of illness, last hospitalization, length of last hospitalization, and previous experience with vocational programs.

Table 3 here

Chi-square analyses and t tests were conducted to determine whether any of the demographic characteristics differed significantly between the two groups. There were no significant differences in gender, number of jobs, educational level, diagnosis, number of hospitalizations, length of illness, last hospitalization, length of last hospitalization or previous experience with vocational programs.

These analyses show that the groups are highly similar on
demographic variables. Both groups consist of individuals diagnosed with major mental illnesses, and a large majority in both groups have been coping with the illness over a span of many years. Consequently, the social and vocational lives of these individuals have suffered tremendous disruption and many have held numerous jobs as they have struggled to cope with the ebbs and tides of their illnesses, medications, and the residual effects thereof.

Mental health services used by each of the two groups were recorded and analyzed. These data are summarized in Table 4. Chi square analyses were carried out to determine whether group differences exist in the area of mental health service utilization. No significant differences were found between groups in the use of any of the mental health services listed by participants: psychiatrist, family doctor, vocational counselling, social worker, case manager or other therapist, volunteer, therapy group, self-help group, drop-in, social, or day program, or crisis unit.

insert TABLE 4 here

Comparison of Empowerment, Social Support, Organizational (Workplace) Climate, and Person-Environment Fit Scores Between Employment Groups

Descriptive statistics (means, standard deviations and ranges) are provided for scores on each of the four instruments: the Empowerment Questionnaire, the Interpersonal Support Evaluation
List (ISEL), the Workplace Climate Questionnaire (WCQ) and the Organizational Culture Profile (OCP), in Table 5. Empowerment scores for both employed (M=2.84, S.D.=.351) and unemployed groups (M=2.94, S.D.=.370) are consistent with those in similar populations. For example, mean empowerment scores at six self-help sites with mental health consumers in the U.S. ranged from 2.75 to 3.79 (Rogers, Chamberlin, et al., 1997). Mean ISEL scores for both the employed (M = 27.59, S.D. = 11.473) and unemployed groups (M= 24.67, S.D. = 9.759) fell between those of other known groups. For example, mean scores for individuals in a smoking cessation program across three measurement periods ranged from 32.9 to 34.4 (S.D. ranged from 4.96 to 5.98) (Cohen et al. 1985) and the mean ISEL score in a study of depressed individuals was 19.9 with a standard deviation of 8.6 (Lara, Leader & Klein, 1997). Person-environment fit scores, as measured by the OCP, showed a larger range for both the employed group (whose scores ranged from -.41 to 1.0) and the unemployed group (whose scores ranged from -.41 to .87) as compared to documented outcomes with a sample of accountants (whose scores ranged from -.36 to .62) (Chatman, 1988). Overall, with the exception of the Empowerment Scale, group means are consistently higher in the employed group.

It was hypothesized that significant differences would exist between the employed and unemployed groups along the dimensions of
empowerment, (2) perceived social support, (3) organizational climate and (4) person-environment fit. t-tests were conducted for each of these hypotheses to determine whether group differences did, in fact, exist. No significant differences were found along empowerment and social support dimensions. (Statistics were \(t(1,34) = -.876; p=.387\) for the empowerment variable and \(t(1,34) = .821; p=.418\) for the social support variable.) Subtests of the ISEL - appraisal, belonging, self-esteem and tangible support - were examined through multivariate analysis of variance (MANOVA) and no significant results were attained. However, significant differences were found in organizational climate \(t(1,34) = 4.05; p<.001\) through the Workplace Climate Questionnaire (WCQ). Differences in person-environment fit were also found to be significant \(t(1,34) = 3.5; p<.01\) through the Organizational Culture Profile (OCP). Thus, Hypotheses 1 and 2 are not supported while Hypotheses 3 and 4 are supported.

Desired Characteristics and Perceived Organizational Characteristics

In view of the significant group differences found in person-environment fit, further analysis of the rankings of specific items on the OCP was carried out with the aim of localizing these differences. Table 6 presents means and standard deviations for the rankings of the desired characteristics by group. Most highly ranked characteristics for the employed group were: enthusiasm for the job; an emphasis on quality; respect for the individual’s
right; being supportive; being organized; fairness; and taking initiative. Characteristics ranked most highly by the unemployed group were: flexibility; respect for the individual’s right; being supportive; fairness; enthusiasm for the job; being socially responsible; and tolerance.

In order to determine whether differences in desired characteristics exist between groups, the differences between group rankings were calculated and effect sizes of each difference determined. Wilcox (1996) suggested calculating effect size by dividing the difference in group means by the standard deviation of the grand mean. Values of .2, .5, and .8 are commonly considered to correspond to small, medium and large effect sizes, respectively. Interestingly, only one characteristic - confronting conflict directly - showed a large effect size, and this is in a negative direction (i.e., the group mean is higher in the unemployed group). Medium effect sizes in a positive direction (i.e., group means are higher in the employed group) are apparent in the following five characteristics: enthusiasm for the job; high expectations for performance, predictability; an emphasis on quality and high expectations for performance. A medium effect size in a negative direction was determined for the being competitive characteristic. Small effect sizes were found, in a positive direction, for: not
having many rules; opportunities for professional growth; risk-taking; being analytical; being calm; being careful; fitting in; taking individual responsibility; taking initiative; working long hours; being organized; being precise; and stability. Small effect sizes in a negative direction were found for: being socially responsible; being aggressive; autonomy; decisiveness; being demanding; being easy-going; a willingness to experiment; flexibility; high pay for good performance; being innovative; low level of conflict; sharing information freely; and tolerance. Effect sizes lower than .2 were determined for the following characteristics; being quick to take advantage of opportunities; working in collaboration with others; paying attention to details; fairness; developing friends at work; having a good reputation; being team oriented; informality; respect for the individual’s right; and being supportive.

Results of this analysis demonstrate that, regarding desired characteristics, similarities between the two groups are more outstanding than differences. The relatively small number of differences found in desired characteristics suggests that employed and unemployed consumers do not differ widely in the workplace qualities or characteristics they desire.

Means and standard deviations were determined in similar fashion for items ranked as perceived organizational characteristics (Table 7). Most highly ranked characteristics (i.e. those that most described the organization) for the employed group were: being careful; working in collaboration with others; paying
attention to detail; enthusiasm for the job; being organized; an emphasis on quality; being team oriented; and tolerance. Most highly ranked characteristics for the unemployed group were: attention to detail; taking individual responsibility; and being organized.

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insert Table 7 here

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Again, differences in organizational characteristics between the employed and unemployed groups were determined through calculation of effect size. This analysis of perceived characteristics yielded a greater number of characteristics which met the criteria for large effect sizes than in the previous analysis of desired characteristics. Large differences in a positive direction were found with regard to being supportive, while large differences in a negative direction were found in being aggressive, being competitive, and being demanding. Medium effect sizes in a positive direction were found with regard to the following organizational characteristics: working in collaboration with others; enthusiasm for the job; fairness; fitting in; an emphasis on quality; respect for the individual's right; being socially responsible; being team oriented; and tolerance, all of which were in a positive direction. Medium effect sizes in a negative direction are evident with respect to being calm and not having many rules. Small effect sizes were determined, in a
positive direction, for being careful, being easy-going, being organized, flexibility, opportunities for professional growth, and sharing information freely. Small effect sizes in a negative direction were associated with: being quick to take advantage of opportunities; autonomy; having a good reputation; taking initiative; being analytical; decisiveness; high expectations for performance; a willingness to experiment; taking individual responsibility; working long hours; and risk-taking. Finally, characteristics which showed effect sizes lower than .2 were: paying attention to details; developing friends at work; low level of conflict; being precise; stability; high pay for good performance, being innovative; and predictability. These results reveal that many organizational characteristics do demonstrate differences in effect sizes, lending further support to the hypothesis that differences in perceived organizational climate can be found between those who maintain their jobs and those who do not.

Correlations Among Variables

Scores from the Empowerment Questionnaire, the ISEL, the WCQ and the OCP were correlated with one another using the Pearson product-moment coefficient. Significant correlations were found between social support and empowerment; social support and workplace climate; and workplace climate and person-environment fit. Table 8 presents these findings.
Factors Associated with Continued Employment: Logistic Regression Analysis

Multiple logistic regression analyses were performed to determine whether any of the following variables predict employment status: gender, diagnosis, length of illness, age, education, previous involvement in vocational programs, scores on the ISEL, the Empowerment Questionnaire, the WCQ and the OCP. Demographic variables were entered in two separate analyses. The first entry included gender, length of illness, and previous experience with vocational programs. The second entry included age, diagnosis and education. None of these demographic variables emerged as statistically significant predictors. In the next analysis, scores from the Empowerment Questionnaire, the ISEL and the WCQ were entered. Only the WCQ emerged as a statistically significant predictor, $B=-.1030, S.E.=.0353$, Wald $(1, N=36) = 8.5082, p=.0035$. Because of the high correlation between the WCQ and the OCP, these variables were initially not included together. When scores from the Empowerment Questionnaire, the ISEL and the OCP were entered, the OCP emerged as a statistically significant predictor, $B=-2.6545, S.E. = 1.1258$, Wald $(1, N=36) = 5.5599, p= .0184$. A final entry was conducted including scores from all four instruments: the Empowerment Questionnaire, the ISEL, the WCQ and
the OCP. In this stage, the WCQ emerged as a statistically significant predictor, $B=-.1021$, S.E. = .0463, Wald (1, N=36) = 4.8618, $p=.0275$. These findings indicate that both workplace climate and person-environment fit are predictors of employment, and that workplace climate may, in fact be the strongest predictor of all of the variables in this study.
Chapter 7: Results of Qualitative Analysis

Presentation of Primary Themes

Themes related to the effects of the workplace and the meaning of work emerged from data analysis, each one having its own set of secondary themes or subthemes. These themes frame relationships between individuals and environments as they impact upon work integration processes and outcomes. They are: the impact of the organization on job satisfaction and tenure, the importance of supervisory and coworker relationships and attitudes, and the meaningfulness of work to mental health consumers.

Exemplification of Primary Themes

The following section contains conceptual analyses of the qualitative data along with verbatim transcript material to exemplify the themes presented.

I. The Impact of the Organization on Job Satisfaction and Tenure

Consistent with the quantitative results of this study, the qualitative findings reveal the importance of the climate and culture of the workplace in maintaining employment and reaping the benefits thereof. All participants interviewed spoke about the interactions of work environments or structures with illness and coping, resulting in various levels of satisfaction and stress. Findings in this area have been categorized into the subthemes of: balancing challenge and predictability in search of satisfaction; psychosocial characteristics experienced at the workplace; and
needs and accommodations in the workplace. Although supervisory and coworker relationships are most certainly elements of and contributors to organizational climate and culture, these issues will be discussed as separate themes.

1. Balancing Challenge and Predictability

Many consumers discussed the dilemma of, on the one hand, wanting to protect themselves from the stresses of risk-taking, and on the other hand, feeling the frustration of minimizing challenge at work. Ann, for example, stated:

in order to hold a job it had to be something that was sort of mechanical enough or automatic enough that I could perform it when I wasn’t well. That meant it couldn’t involve too much creative thinking, or too high a level of responsibility, or a whole range of other things, except that meant something that in fact was sort of below what my professional ability is.

Vera described the dissatisfaction she experienced from performing a "safe" job below her abilities:

I don’t enjoy being very good at something and not doing it and not being allowed to learn more about it and not being able to find ways to do things, but having to turn anything that’s interesting over to somebody else, so they can find out.

Gary summarized the dilemma:

It has taken alot to understand my illness, and the triggers that can bring it on. So now, I avoid the triggers...the risk taking you minimize now and become ultraconservative ...a tendency to shy away, which can be frustrating because you know, before I was sick I would do that, I would take it on or attempt it. Now that you’ve been sick you say to yourself, that’s going to get me in trouble, mentally it’s going to mess me up.

Finally, Susan offered advice based on the trial-and-error process
she went through to find the right balance:

I think try to give the person with mental illness as much responsibility as they can take. But not force them to take it. And this may be a trial-and-error process. Of course it's important for them not to feel that people with mental illness can only get the lowest of low jobs...I have a high IQ and I would not be satisfied doing a Joe job I don't think...although I am now sort of doing a Joe job. But I know that I am doing what I can do with my limitations. Cause I've done it by trial and error. And so I'm happy. If you put down the person and not allow them to grow, then there's going to be dissatisfaction. Whereas if you let them grow and do as much as they possibly can do...you're going to get alot.

Finding work which offered the right balance of challenge and predictability or the flexibility to shift emphasis was difficult for consumers. The effects of imbalance in this area on job satisfaction are evident; the question of whether job performance and maintenance are affected warrants further exploration.

2. **Psychosocial Characteristics of the Workplace**

As expected, a wide range of workplace characteristics were experienced and described along with highly individualized opinions and reactions to them. There was, however, emphasis placed by most consumers on the importance of a friendly, respectful, communicative work environment with a culture of flexibility and inclusion. Many stated they enjoyed a relaxed, easy going environment with a minimum of competition. Unfortunately, many consumers in both groups conveyed examples of stigma and prejudice at the workplace, but these were particularly intense for those who left their jobs, in some cases with stories of unjust treatment.

An atmosphere of respect and caring, and an ability to see
beyond the illness, appeared to be most valued for participants. Randy stated:

My employer stuck by me while I was on disability, and they challenged me to come back to work...I worked amongst people who ignored the fact that I had a weird appearance but I did the job and they stuck by me.

Robert, a clerk at a law firm, described that despite some uncomfortable elements at his workplace, basic respect is offered:

There’s a lot of nice people there, you have to be very careful of the way you act, cause they have lots of lawyers, the president,...but they’re very laid back there even though they have these important people, they let you do whatever you want, they’re very easy-going...they don’t really seem to care that I have a psychiatric illness, they treat me like a regular person, just a regular guy who works there. I think they’re very competitive and that makes me feel bad sometimes because I’m not that much a competitive person, and sometimes you can take it the wrong way.

Vera and Gary summarized the importance of communication and respect in their advice to employers: "talk to someone regularly and say how are you getting along, having any difficulty? ...without prying"; "don’t treat them like a baby or a dawdling old fool. Give them credit where credit is due. And accept them."

Tolerance, acceptance and flexibility were emphasized by many consumers. Leslie stated:

I feel like I fit in here, because it’s a friendlier place, and plus I can get up from the desk here at any time and just chat for a few minutes with the people in the lounge or to another staff person. I find my concentration level is much shorter now, since I’ve been ill, I just can’t sit for as long. It’s perfectly acceptable for me to just get up here...whereas in previous places I’ve worked you were at your desk, you stayed at your desk all day and you never moved...

Leslie further analyzed her workplace and concluded that flexibility was an element of the culture of the organization, as
opposed to an accommodation made for people with special needs. She stated: "they’re flexible with all the staff around days, not just me. You know it’s a very flexible office in that sense."

Inclusion in the life of the organization was also described as an important factor contributing to job satisfaction and commitment. Susan, a clerk in a accounting firm enjoyed sharing her examples of social inclusion:

After tax season...the firm gives a tax party and they can let off steam and bash...everybody goes to this party...I used to hate it because I couldn’t join in because of my medication...And now I leave early. I stay for dinner and even though I leave early I enjoy it. And then there’s golf day which is my favourite day of the year...we all go golfing...it’s a fun day out, it’s outside and then you get a free lunch and dinner...I won the trophy a couple of times.

In contrast to some heartwarming stories told by working consumers, there were examples of stressful environments experienced primarily by those who had left their jobs. Matt, working at the time of the interview, recalled the stress of a job he had left in the past: "I don’t like working with that much hostility, it wasn’t good for a lot of people under the cloud of losing their jobs...and to treat them like they’re all petty criminals...it wasn’t a good work setting."

Some consumers who left their jobs complained of being treated differently by peers and coworkers once it became clear that there were mental health issues. Maggie stated:

...there seems to be the assumption that we’re not quite people. That you’ve got to treat us with kid gloves, otherwise we’ll get all depressed, you know. Once you treat me the same as everybody else, that lets me know that I’m here and I’m OK and then I can be like everybody else. If you start treating me differently, saying "you
better get that coffee for Maggie, didn’t she say she was manic-depressive - she might go off the wall. Or if she doesn’t have her caffeine, maybe she’ll have a reaction to the drugs..." If you start treating me differently, then we’re not going to talk anymore. This is my experience.

In some cases, unfair treatment on the part of the organization was described. Kira, a teacher, outlined a series of events leading to her dismissal:

I got this famous letter that just about destroyed me...it talked about things like I didn’t hand in my attendance forms, and they were found in disarray...they said I had left the kids in the library unsupervised for fifteen minutes. Now I’m a real sucker for the kids...they didn’t want to shlep their bags with them so I ran around to find a teacher to lock the door so their stuff would be safe...they didn’t say anything to the head librarian though, and she and I had been really good friends, and as she rose through the ranks she stopped talking to me.

Thomas, who took some time off work for mental health reasons, described the disappointing process of trying to come back:

I worked there for seven years. There were some rough patches, but overall I did pretty well... When I was ready to come back I wrote a couple of letters and left a few messages, and received nothing. When somebody feels ready to come back, and you’ve had no contact, no understanding, you figure [they are saying], well, we’ve got rid of him. And that’s where you stop dealing with them...I was angered and hurt by that but not entirely surprised.

In contrast to working consumers who described a climate of acceptance, respect and recognition of their personhood, stories such as these from consumers who were given no choice but to leave point to the wide array of responses to mental illness and the negative effects of intolerance at the workplace.
3. Needs and Accommodations in the Workplace

The development of awareness of personal needs along with accommodations in the workplace to meet these needs, were described by working participants as facilitators to work. Interestingly, however, there was very little articulated on this topic by those who had left or lost their jobs, presumably because accommodations were not components of their work experiences.

Stories of accommodations were told with great importance attached to them, often tempered with statements around balancing personal and employers' needs. (Ann, for example, advised consumers: "Know what you need to know, negotiate the working situation...that's what we're entitled to, and on the other side be aware that there are limits.")

Accommodations related to time flexibility were cited frequently and in many ways as factors enabling continued participation in the workforce. Ann gave a vivid example:

one of the best things I was able to negotiate during the last period when I wasn't well was that I could be in the day treatment program part-time, and work part-time. And it was at a point when I absolutely could not have been in the day treatment program full time because it just felt like that was the end of my life... And there was no way that I could just carry on full time at work. So the ability of both the program and the workplace to say let's work with this helped.

There was also discussion of the need for time flexibility by nonworking consumers who were not offered opportunities in this area. For example Karen stated: "if you’re depressed you may need to take a couple of weeks off, and that’s just the way it goes, doesn’t mean it’s going to affect my entire job, it just means I
need a couple of days rest to get through the next 365 days of work." Lack of flexibility posed difficulties which increased job stress. Donna, for example, described the events leading to her job loss:

I had to be at work at a certain time in the morning and I had to have this certain uniform, basically I had one shirt and one pair of pants but it had to be clean all the time... and I felt I had to overextend myself a lot, I would try to juggle with the time to do everything and always got to work late... I'm looking in the paper for jobs that could be flexible right now.

Time flexibility in combination with restructuring of job duties was discussed as a helpful strategy. John described the process that enabled him to continue working through his illness:

my manager made accommodation for me, gave me some time off and reduced the hours... I started sleeping better so I was getting back up to par because to be honest with you when I wasn't sleeping it was hard to concentrate. I feel like I'm doing a better job now. But they were willing to work with me - they didn't just tell me to take two months and go away, they helped me work through it and stay on the job. My hours were reduced, some of my paperwork was put on hold and now I'm just starting to get caught up. I was still at the workplace - on reduced duties but nevertheless I was still there.

Alterations to duties and responsibilities in accordance with changing mental health needs made a difference for many consumers. Susan described:

My supervisor, she knows me pretty well by now. If I get sick, she won't expect me to make the same decisions that I do when I'm well. She'll help me make decisions if I want her to. If I want to be in hospital and work a couple of hours a day... just to do a bit of filing, do whatever possible, I can do that. My other responsibilities are taken over by her or somebody else in the department.

Ann underscored the importance of restructuring duties at needed
times: in her case, complex duties were substituted with simpler and more highly structured ones. She stated:

(my supervisor and I) would do some strategizing about what needed to happen in order for me to manage. And usually then we’d do sort of a series of things, like offload a number of projects that other people would take on, have me do some more mundane kinds of things, have me have a very specific schedule for the day that would say these are the things that I’m working on today and tomorrow I’ll check in with my boss and see how that’s coming, and bring a lot more structure.

Accommodations to the job were not only helpful in managing the stresses of work and coping with illness, but served to convey attitudes of concern and caring from employers. Undoubtedly, this in turn fostered greater job satisfaction and a deeper commitment to work.

II. The Importance of Supervisory and Coworker Relationships and Attitudes

The nature of supervisory and coworker relationships was a factor affecting quality of work life and maintenance of the job itself. Some consumers paid tribute to their supervisors and coworkers for their qualities and efforts; others pointed to the need for education and change. This theme has been categorized into three subthemes: the influential nature of supervisors’ qualities and behaviours, the impact of coworker relationships and attitudes, and the dilemma of disclosure.

1. The influential nature of supervisors’ qualities and behaviours

Virtually all consumers interviewed spoke about their
supervisors and the impact of this relationship on their ability to stay at work with some degree of satisfaction. Most working consumers described positive relationships with their supervisors whereas non-working consumers had many more negative or mixed feelings in this area. In general, supervisor qualities which were valued by consumers included willingness to provide feedback and to communicate openly, fairness, commitment, supportiveness, a sense of humour, and an ability to convey the worth of the employee.

Matt described:

I always enjoyed having feedback, positive or negative, obviously positive is better. The supervisor I report to is fairly even-handed and deals fairly and consistently with everybody. He goes out and does the grunge as opposed to just sitting in the office dictating...I think it’s very inspiring for people working under him to see that he will go out and do tasks that he expects people who report to him to do and that makes a very good contribution. And when you see that this person is concerned and takes part in what they’re doing and in the people who report to him do, it makes for a much more complete workplace and it’s not as polarized.

Robert talked about the support he experienced from his supervisor:

I have a female supervisor and she’s very supportive...When I started she was the one that helped me, she was the one that took me under her wing and showed an interest in me. She made me realize that this was really a nice job, she really takes the time to ask you little stuff, she’s a very nice person...(when I became ill) I’d be crying and she’d give me tissues and be asking if I’m OK. And of course I don’t want to say anything so I’d be saying, yeah, I’m fine...

Ian emphasized humour as an aspect he enjoys:

well (my supervisor) and I can joke around with each other, you know, he’ll insult me and I’ll insult him back...it’s like we got a good relationship going. We joke around all the time, we do that but we both have our serious sides.

The ability of the supervisor to help employees feel valued and
appreciated was described by Susan:

Mr. X, my dear, dear friend...he has played a large part in my getting the job, without him I probably would have freaked out, but he says I’ve taught them more lessons than they’ve taught me. I’ve helped people understand about schizophrenia.

Non-working consumers had different feedback about their supervisors and the relationships or absence of relationships with them. Most of them described a lack of support from their supervisors and in many cases, attributed increased stress at work directly to their supervisors. John explained that "I could not use (my supervisor) as a support or confide in him...I’d look at him and put myself down immediately, just like I’m not doing good enough and it would cause major anxiety." Donna described the stressful interaction with her supervisor after realizing that as a single mother, she could not get to work on time:

Well she just told me that it wasn’t acceptable...you know that the requirement of the job was to be there on time or even a few minutes early...and then she said that I got defensive...I was so stressed out at the time, I was overtired and nervous and then I apologized and she said well I can’t deal with you, you’ll have to speak with the owner about this...I never did get a meeting with the owner. And later on she told me that he had turned the responsibility of dealing with it over to her and she didn’t want to hear any excuses or anything.

Leaving the job appeared to be, in some cases, a direct result of unsatisfactory relations with the supervisor. David stated:

as soon as the new manager took over that’s when I quit, because he was a young punk who thought he knew everything, he thought he was big hot stuff...and he used to take his problems out on the staff, his marital problems...he wasn’t too good.

Karen, not working at the time of her interview, summarized her wishes for an ideal supervisor:
a supervisor to be able to sit down and talk about the frustrations I’m going through once a week, or once a month, how are things going for me, what kind of frustrations am I up against. I think that’s very important for a supervisor to take into account. And to find out that I’m a worthwhile person...

The effects of the supervisor on work life have been widely documented in management literature. The qualitative research findings of this study concur with research pointing to the significance of this factor and underscore the importance of social factors in work integration outcomes.

2. The impact of coworker relationships and attitudes

The qualitative nature of relationships with coworkers was an element of importance conveyed by participants. In similar fashion to relationships with supervisors, some consumers described supportive, friendly relationships with their coworkers while others described quite the opposite. Once again, working consumers were more likely to fall into the former category. Randy described the enjoyment he experienced from being around his coworkers:

I have a chance to meet people on a regular basis, especially like the pretty girl at work you know, get dressed up to go to work ...it’s something to look forward to and you know when you meet them and they’re friendly and they appreciate someone who has an illness that goes out and makes an honest day’s wage, it puts a smile on their face.

Robert also derives satisfaction from interactions with his coworkers:

...they talk to you alot and they say you’re doing a good job, stuff like that. You know that when you start getting things like more responsibility you realize that you must be doing something good.
Coworkers who demonstrate attributes which contribute to positive work climates were valued by participants. For example, Randy explained how the culture of acceptance at his workplace emanates from his coworkers:

the people I work with, they understand I have an illness, and sometimes if I say something strange, and it just doesn’t register with them, you know, they’ll just say, that’s OK Randy, I mean that’s the way you feel about it, they accept me as I am.

Once again, contrasts between the quality of relationships described by working and non-working consumers became evident. Many stories told by consumers who left their jobs contained examples of intolerance, conflict and confusion about their relationships with coworkers. As an example, Monica described the negativity she encountered from her coworker:

it was very evident she didn’t want me as a friend. That’s a social thing but it really felt bad to me. And she was competent. I think she resented the fact that I often asked the other girls questions...she didn’t want any questions herself so she just didn’t talk to me and it felt bad that one of the people where I worked really did not like me.

Kira had a similar experience with her coworker:

there was definitely something, it was somehow I had slighted her...her face used to beam when she saw me, we took our kids to Wonderland, we went to lunch, we spent time on professional development day...and suddenly she’s ice cold to me. So I was going to approach her and say Wendy is there something that I’ve done to you? And my social worker said to me stop assuming that everything is your fault, that you’ve done something wrong, so I left it.

Relationships with supervisors and coworkers clearly had an impact on self-esteem, quality of work life, and in some cases, ability to maintain the job. Ann summarized its importance:
the more focus you put on the relationship and building communication, managers and employers sorting out their needs and wants and what their expectations are and what they're prepared to do and what they're not prepared to do, and the more the individual can do the same thing, and work with "OK where do we meet?" in a way that works for everybody. It's about the relationship.

3. The dilemma of disclosure

There appeared to be no trend within groups regarding the decision around disclosure of mental health problems. Each of the two groups consisted of those who chose to disclose some part of their mental health problems and those who chose not to. The difference that did emerge was the manner in which this information was received when disclosure did occur, as discussed in previous themes on psychosocial characteristics, accommodations and supervisory/coworker relationships.

The decision to disclose or not to disclose mental health problems at the workplace was described by most consumers as a difficult one, one which carried consequences in both directions. Although disclosure relieves the burden of secrecy and often leads to accommodations to be made to the job, consumers hesitate to disclose, all too aware of societal stigma and the range of potential reactions. As stated by Linda, "I haven't felt comfortable about (telling), I mean I wish I could in a way, but I don't know how they would receive it". Matt further described the difficulty:
Somewhere it feels wrong to say nothing, but then in another way it feels wrong to say something, I don’t quite know how to reconcile the issue of disclosure. I guess that comes from being burned by the issue of disclosure...I wasn’t fired but it was a leave of absence.

Some consumers were selective about the individuals in whom they confided at the workplace, making sure that trust was well established so that disclosure was safe. Ken stated:

I don’t want to mention it to anybody, cause there is that stigma. There is a guy at work where I can talk about it. Very good, compassionate, actually a few people know about it. It’s something you don’t brag about...there is the stigma...what happens is that you don’t lie but you don’t tell the truth.

The decision to disclose was described by some consumers as a function of the workplace climate and culture. They believe careful assessment of the culture is warranted before making this important decision. Gary, for example, holds down two part-time jobs and has made different decisions at each one:

I know that the one department I’m in, the bosses that I have, my illness doesn’t seem to worry them or cause them any concern. Now another part-time job that I have...I wouldn’t breathe a word that I have a mental illness, because I knew if I did, I’d be long gone out of there...I see what happens to people who get sick there.

Some consumers made the decision to take the risks associated with disclosure because the stress of keeping it quiet was too great. Linda stated:

I knew for me personally, I had to be in a place that knew. I wasn’t going to hide it anymore. I couldn’t - it was too hard to hide all those years that I was working in accounting, and I wasn’t willing to go on hiding it anymore.

Still other consumers felt that disclosing their illnesses to their
supervisors and coworkers was an act of responsibility. Randy, for example, stated:

well I think the employer has a right to know because they're going to pay you a salary, they're going to give you all sorts of benefits to look after your disease. It doesn't hurt to tell them up front so that if something does happen, they're able to handle the situation properly...when a new coworker comes in and I explain I have this disease and there may be things that seem odd to you while you're working with me, but don't worry it's not harmful to you...when I ask my coworker "what do you think of that" he says "it's very interesting, I've never seen that before" but the point is that we joke about it.

Many working consumers who disclosed their illnesses were subsequently able to accommodate their jobs to meet their needs and therefore described disclosure as a positive step:

I had to tell them, and I was glad I did, because now I've got a job that I can do and there's flexibility and there have been allowances made and I can do the job to the best of my ability, whereas if I had been in a situation where my boss didn't know, I probably would have been out the door the first time I was sick.

The dilemma of disclosure in and of itself is reported to be a source of tremendous stress at work. The difficulties associated with this decision are the result of lived experiences reflective of societal attitudes and stigma. Organizational cultures whose norms do not accommodate diversity, acceptance and other positive psychosocial attributes are less likely to foster honesty in this area amongst their employees. Consequently, energies are devoted to hiding the illness and managing components of the job which may not "fit" well, thereby minimizing the likelihood of successful and satisfying work.
III. The meaningfulness of work

Both working and non-working participants related employment to positive effects on health and self-esteem, although there were, in some cases, qualifiers to this relationship. Some individuals spoke of the need to find a balance between the positive effects of structure, productivity and improved economics, and the negative effects of their experienced work stress. Generally speaking, however, there was an expressed wish to be competitively employed in some capacity in order to feel personally satisfied and fulfilled. The sense of general wellness associated with work was contrasted to subjective feelings associated with unemployment and even underemployment, and these states were described many times, in many ways. Robert stated: "when you’re working you have pride in yourself and you feel important and you feel very good about yourself, when you’re not working, you’re down and you’re depressed and it’s lonely." John reflected on being not only unemployed but underemployed:

being underemployed is very frustrating, it caused me to feel anger: I would work quite hard and not be paid very much money and not have enough to make ends meet and I found it very frustrating and while I was underemployed...I went back to school...and took a gas fitters’ course...at one point I offered to work for nothing for one or two months to get experience and I was turned down, so I felt really, really badly...I just felt like giving up and it was actually after that I started to get depressed about being unemployed because it was dragging on longer and longer...I became totally withdrawn...you know, things when you’re depressed, sometimes they feel hopeless.

In accordance with the vast literature on employment and well being, mental health consumers described work as a vehicle which
enabled fulfilment of numerous human needs. These descriptions have been analyzed and categorized into secondary themes: work as contribution to society, work as distraction and "normalization", and work as challenge, achievement and self-worth.

1. Work as Contribution to Society

Both working and non-working participants spoke about the importance of "giving back" to a system, of knowing and having others know that they are active participants within a collective. John, unemployed at the time of the interview, stated: "right now I’m going on family benefits, at one point I thought I was going to be on it permanently but thankfully I’m getting back on my feet, I like to pull my own weight, I like to support myself and to contribute to society." Randy emphasized that being a contributor is even more important to him as a person who may require assistance:

I basically like to be a contributor to the system, instead of taking away from it...even though I have a legitimate right with an illness, I just feel better about being part of the people who are making an effort... people will understand that I am doing what society asks and trying to rebuild my life...they’ll go to bat for me in a sense.

Matt described a similar sense of commitment to society, one to which he was socialized in his earlier years:

from the way I was brought up, I was taught to value work, that the work you do is the rent you pay for the space you occupy on earth ...my father, from the example he set, showed the value of work - there’s remuneration, and it accomplishes other goals, but it comes down to where you have to make a contribution.
Contribution to society at large was, in some cases, an indirect result of the pressing need to contribute to one's more immediate world. Gary, a single father, stated:

I feel like I'm accomplishing something, like I'm contributing something...and it has some kind of meaning or purpose... I'm getting satisfaction. I'm a single parent raising my children. I know the money I receive for working is going to benefit them, cause I could provide things for them...a nice stable, safe environment, where they have food, shelter, bedding, you know, and some luxuries in life.

Consumers, who have long been advocating for deeper integration into mainstream society, are clearly stating that full community participation is the order of the day. Work is viewed not only as an opportunity for self advancement, but as a set of "citizenship behaviours" to enhance the life of the community at large.

2. Work as Distraction and "Normalization"

The pervasive and, in some cases ever-present, effects of mental illness were described by participants as a burden to be borne throughout their lives, alleviated to some extent by work. Ian stated:

[when I was unemployed] I was around the house all the time, being bored...getting depressed...now that I'm working, I haven't been depressed that often...I still do get depressed but if I'm working I don't think about it, I'm too busy.
Unemployed participants tended to agree with this position. Mark, not working at the time of the interview, stated:

when you’re working you don’t have time to worry about life or sit back and think too much, you know it’s just routine and I like a routine of getting up and going somewhere and having fulfilment during the daytime... and it’s hard for consumer survivors cause there’s not much out there.

Randy, who proudly reflected on his long tenure at his job, felt that work helped him to avoid triggers to his illness:

(work) takes me away from the television, there’s no opportunity to watch television...because when I get near television, strange sort of things happen, it brings me back to the nuts and bolts of my condition...it aggravates my illness.

Work was emphasized as an activity which shifts one’s focus from differences which exist between persons with mental illnesses and others, to similarities. As Susan stated, "There, I’m a worker who does a good job, gets paid and earns a living like anybody else. I’m almost normal." Bruce confirmed this view, stating:

it means alot being integrated with the rest of society in alot of ways, maybe not socially, but as far as working goes, I’m leading more or less a normal life, just like anybody else. That’s what it means to me: being able to perform a job, seek money for it...be recompensed. And those are things that everybody needs.

In fact, work was seen by some to be the link that maintained all other elements of an integrated and satisfying life. For example, Ann reflected:
not having a job seemed scarier to me than just about anything...when I was most depressed the vision that would go through my head would be well, I won't be able to keep my job and so now I won't have enough money to keep my apartment and the like and I don't want to lose contact with my friends, and a whole scenario would result from that...

For many mental health consumers the ability to work offered hope for and realization of the goal of reintegrating into mainstream life. At the same time, in a very concrete sense, work put forth a new set of demands and activities, which interrupted the pattern of attentiveness to pathology which had previously occupied so much time and energy. A shift from a focus on illness to a focus on wellness was facilitated.

3. Work as Challenge, Achievement and Self-Worth

As is true for many people, work was described by mental health consumers as a set of opportunities to seek out and meet new challenges, experience a sense of accomplishment, and thereby validate and develop self-esteem and a sense of self-worth. For consumers, virtually all of whom described experiences related to illness, stigma, and marginalization damaging to self esteem, the rebuilding of the self was seen to be critical and connected to work. Working and non-working consumers alike spoke of the interplay between the challenges of employment and self worth. Randy stated:

Answering the phone and meeting a deadline, some broker in another part of the country needs a prospectus for tomorrow, well you make that little effort to get it to them so that it gets in the mailbox that day for them. I like the challenge of having deadlines, it does challenge
my ability to get things done...the ability to accomplish things, that success in achieving the things I set out for myself and for others each day is very important. I get alot of personal satisfaction out of that.

Louise described how work enabled the development of self awareness and affirmation of ability:

It gives me a sense of accomplishment, to work again, putting in the hours and realizing that I can do that and not fall apart and give up. Something wonderful has been happening in the past two years, because I have started to believe that I can actually work in a job and receive a pay cheque for that...so there’s a certain worth there, that’s been growing, that’s gotten stronger and stronger. That good feeling keeps me going back and back.

Susan echoed these positive feelings resulting from a job well done:

It makes me feel important. I know what I do is not the most important job in the office but I know it’s my job and I know I do it well - and that’s important...they see that I’m a little bit different from them, really. Still, I can function and do a job. My boss finds me a valuable person and so they do here. I must have some value.

Some consumers compared subjective feelings of self-esteem while unemployed and employed. Ben stated:

If I’m not working I feel lousy. Working builds up my self-esteem...I know when I was unemployed and not doing a job, getting assistance, my self-worth went down. There was this feeling that nobody wanted you. You felt like a criminal.

Gary agreed:

Work gives you a sense of self-worth. When I don’t work, you know your mind plays tricks on you...you wonder, what good am I? What goes through my mind is you’re worthless...why the heck are you on this earth anyhow, you know, if all you’re doing is vegetating, cause you’re not doing anything.

Non-working consumers reflected on differences in self-esteem as well. Kira, who described work as "a definition of my integral
worth" reported that "my self-esteem has really gone down the tubes over the time I haven’t worked." Monica speculated "it would do quite alot for my self-esteem if I could find a job that I could handle to my satisfaction...it doesn’t help when other people say you’re doing fine when inside you think you’re not giving what has to be given." Consistent with literature on motivation and self-efficacy, it appears that satisfaction derived from achievement and mastery serves to foster the development of self-esteem, perceived self-efficacy and motivation to persist.
Chapter 8: Discussion

In this study, the experience of work integration for mental health consumers was explored. Four variables in particular were examined for potential relationships to employment: empowerment, social support, organizational climate, and person-environment fit. Data was gathered on two groups: one group of mental health consumers who were employed in integrated settings, and a second group of consumers who had recently left their jobs (willingly or unwillingly). Quantitative data on each of the four variables were collected and analyzed. Qualitative data through semistructured interviews were also collected for purposes of content analysis.

Quantitative data analysis showed that, while significant differences do not exist between groups along empowerment and social support dimensions, such differences do exist for organizational climate and person-environment fit. Furthermore, although consumers do not differ widely in characteristics they desire at work, perceived differences in the workplace with respect to particular characteristics are evident. The climate of the workplace and the degree to which personal and work values "fit" were found to be significant predictors of employment.

Qualitative data analysis revealed themes consistent with quantitative findings in that an emphasis was placed upon interactions between persons and environments as they relate to work integration. The importance of work to the health and quality of life for mental health consumers was validated.

There are a number of major implications of the findings of
this study for mental health professionals, vocational rehabilitation practitioners, employers, consumers and organizational researchers. The major finding to be disseminated from this work is the impact and significance of the work environment in understanding and promoting employment for consumers of mental health services. The culture and climate of the workplace and the extent to which the values of persons and work environments fit with one another were found to be important factors associated with continued employment for consumers. In contrast to previous research on predictors of employment, which has generally concerned itself with demographic and clinical variables, this research promotes a shift in focus from the individual to the environment in understanding the process and outcomes of work integration for mental health consumers.

The results of this study support the results of several studies which have found a lack of relationship between such individually-based variables as diagnostic category and vocational outcome (Rogers, Anthony, et al., 1997; Schein, 1997). Demographic variables such as gender, age, length of illness, diagnostic grouping or number of hospitalizations also did not emerge as statistically significant predictors of employment status. Not only was there no significant difference in demographic variables between employed and non-employed groups, but narratives of the participants revealed that some individuals who had frequent episodes of illness, lengthy histories and numerous hospitalizations also had long tenure at their jobs and derived
great satisfaction from them. The climate of the workplace emerged as a significant predictor of employment status in this study and this issue was the focus of much discussion on the part of the participants. Some research in the area of work integration does highlight the critical nature of external variables such as support on the job (Mchugo, Drake & Becker, 1998) and the workplace context (Jongbloed, 1996) in assisting people with mental illnesses and other disabilities to remain employed. A few researchers have gone so far as to suggest that cultures of workplaces be observed in order to maximize social inclusion of employees with special needs (Hagner & DiLeo, 1993; Hagner, Rogan & Murphy, 1992). The findings of this study bring these environmental issues into sharper focus, revealing a significant relationship between employment status and workplace climate.

This study identified specific characteristics of the workplace that may be facilitative of continued employment for mental health consumers. The finding that very little difference existed in desired workplace characteristics between employed and non-employed consumers suggests a degree of universality in consumers' needs for a humane and affirming place to work. Irrespective of employment status, wishes for the workplace revealed through both quantitative and qualitative data analysis included enthusiasm, respect, fairness, and flexibility. However, there were significant differences in the perceived realities of the work settings for employed and non-employed consumers, suggesting a relationship between perceived characteristics and
continued employment. Employed consumers perceived their workplaces to be more supportive, fair, collaborative, tolerant, respectful and socially responsible, amongst other things, while non-employed consumers perceived their workplaces to be more aggressive, competitive, and demanding. The effects of components of climate on individual behaviour and attitudes within organizations have been demonstrated within the general population and is well documented within management literature (Ostroff, 1993).

An important theme in this study was the difficulty consumers experienced in balancing challenge and predictability at work, the conflicted wishes to meet their potential, placed against a backdrop of fear of recurrence of illness. This finding is interesting and revealing when considered alongside research from management literature which suggests a relationship between level of work demands and job tenure. The Whitehall II study, for example, measured work characteristics and found high job demands, including conflicting tasks, work overload, role conflict and high work pace, to be associated with increased risk of psychiatric disorder for both men and women (Stansfeld, Fuhrer, Head, Ferrie & Shipley, 1997). Also revealed was the protective nature of skill discretion (a measure of job variety and opportunity for use of skills at work) and decision authority (the amount of control over work) in men against psychiatric absence, leading the investigators to conclude that "interesting and varied jobs tend to encourage people to stay at work at the time of mental health difficulties, rather than take absence" (p.78). When considered in light of
studies such as the Whitehall II, the importance of finding, not simply a job that one is capable of, but rather one that offers a satisfying balance between challenge and predictability, becomes a critical area of focus in work integration.

Congruence between personal and workplace values has been documented as an important feature affecting work life for the general population (Chatman, 1989) and this appears to hold true for consumers of mental health services as well. Findings which focus on person-environment fit support those of a limited number of studies which demonstrate improved outcomes for persons with psychiatric and other disabilities, when employment was obtained in preferred areas (Becker, Drake, Farabaugh & Bond, 1996; Freedman, 1996), pointing to the importance of compatibility between the worker and the workplace. Person-environment fit scores were significantly higher within the employed group; this variable was found to be a significant predictor of employment status and information derived through participant narratives was consistent with this finding. These results underscore the importance of assessing workplace climate and its congruence with individuals’ value systems as part of the work integration process. Clearly, the environment of the workplace and its impact on mental health consumers is an area in need of further discourse and empirical research in order to more effectively address work integration issues.

Consistent with the results of a limited number of studies on factors external to the individual consumer and work (Akabas, 1994;
Gates, 1993), the importance of supervisory and coworker relationships in the creation and transmission of workplace culture and climate emerged as another important finding. Again, much has been written within organizational theory to make sense of this principle. Mayo and his colleagues, in their early and renowned Hawthorne studies, explained that their findings of increased output under a variety of conditions were a result of workers' needs for acceptance and attention from their superiors and argued that supervisors should be trained to be more sensitive to worker needs and that doing so would increase satisfaction and effort at work (Mayo, 1945; Roethlisberger & Dickson, 1939, as cited in Walsh & Tseng, 1998). More recently, the Whitehall II study revealed that support from colleagues and supervisors at work was protective of mental health in both men and women as measured by the General Health Questionnaire and short absences for psychiatric reasons (Stansfeld et al., 1997). The investigators pointed out direct implications for management and work organization, stating that "attention to support of employees by supervisors is likely to improve mental health and reduce rates of short spells of sickness absence and thus may lead to an overall increase in productivity" (p.78). Furthermore, visionary leadership theory addresses specific personal characteristics and actions that a leader takes to create cultures that strengthen the organization and meet human needs (Sashkin & Burke, 1990). Specific leadership qualities have been found to be facilitative of positive worker behaviour, and these relationships resonate with the findings of this study. For
example, Farh, Podsakoff and Organ (1990) found that leader fairness and support were positively associated with altruism in employees and Konovsky and Pugh (1994) found that perceptions of fair decision-making and trust in supervisors was associated with organizational citizenship behaviours or active cooperation at work. Similarly, in this study, positive relationships with supervisors and coworkers were highly influential forces in the work lives of the participants and were seen by consumers to be factors which promoted continued employment. In view of these similarities, it may be said that this research begins to bridge the gap between that which is well known to organizational behaviourists in promoting the health and productivity of employees and the individually oriented approach which has typified research and intervention with consumers engaged in the process of work integration to date.

Not unrelated to workplace culture and coworker/supervisory relationships is the dilemma of disclosure, discussed in depth by participants in this study. The fears and anxieties associated with disclosure, the benefits which resulted for some consumers and the stigma experienced by others, point to the complexity of this issue and underscore the importance of attending to the decision around disclosure with great care. Robert, Rotteveel and Manos (1995) discussed disclosure for mental health consumers as professionals and cautioned that the decision around when, how and how much to disclose depends on the culture of the workplace. They advised that consideration be given to ways in which staff support one another,
formal or informal mechanisms that enable such support to be experienced, and the level of tolerance for discussing personal information. MacDonald-Wilson and Whitman (1995) also offered tips to assist with the decision of whether to disclose, including an assessment of the employer's attitude and openness as well as his/her experience with employing people with psychiatric disabilities; the acceptance of coworkers; and the direct supervisor's experience with giving constructive feedback and his/her general management style. As emphasized by this study, the magnitude of the issue of disclosure and its impact on work is a call for assistance for consumers in the throes of the decision. The negative consequences, stigma and social exclusion, must be balanced against the relief and freedom to be oneself as well as access to reasonable accommodations on the job following disclosure. The emphasis placed on disclosure in this study serves as a caveat to vocational counsellors, mental health professionals and consumers, to consider contextual aspects of individuals' workplaces as well as the values of the employee in making this decision so that beneficial results may be attained.

Two additional variables, empowerment and social support, were also examined in this study relative to employment status. The finding that no significant differences existed between employed and nonemployed groups across these variables was unexpected. This may, in part, be explained by the sample of participants, many of whom came forward from consumer groups or programs, or were informed of the study through word-of-mouth or a widely circulated
consumer bulletin. Engagement in such groups, programs and social networks in and of itself likely addresses needs around social support and empowerment. In fact, significant positive correlations were found between empowerment and social support. Most participants in the study had lived with their illnesses for some time, and had become informed consumers with well-developed support systems. Interestingly, the lack of significant findings in the area of employment and social support relates to findings of Stansfeld, Bosma, Hemingway and Marmot (1998) who found no evidence that personal social support moderated the influence of work characteristics on functioning in the Whitehall II study. Lack of significant findings in the area of employment and empowerment is consistent with those of Rogers, Chamberlin, et al. (1997) who found no differences in empowerment between working and nonworking consumers recruited from self-help programs. Significant positive correlations between empowerment and social support were found in both studies as well.

There were several limitations to this study. Sample size was small, as recruitment of consumers was a lengthy and difficult process. Therefore, the procedures of this study must be replicated with larger groups. This research is cross sectional, showing significant associations among factors, but it is not able to show causal relationships. Future research needs to assess these factors over time to determine a more precise understanding of these relationships. Furthermore, recruitment of consumers who value work but are not connected to programs and services may shed
further light on the relationship of social support and empowerment to employment outcomes.

The meaningfulness of employment to consumers of mental health services was an important and pervasive theme which emerged from this work. Participation in the workforce was seen as a health promoting life role which enabled a shift from pathology to productivity and a development of self worth and life satisfaction. Consistent with findings associating employment with health and well-being within the general population, consumers in this study described improved mental health and self-esteem and a more integrated, "normalized" way of life. The relationship of work to health has once again been highlighted and to this end, further research on factors facilitating employment is needed. Specifically, research which has as its focus not only the individual and the restrictions that result from mental illness, but also social factors and environments which facilitate active engagement in the workforce, is recommended. It is through further examination and construction of work environments that facilitate productivity and satisfaction that mental health consumers will attain and maintain their rightful place in the workforce.


APPENDIX I

Factors Affecting Work Integration for Mental Health Consumers

Information Letter to Potential Participants

Dear Potential Research Participant:

I would like to invite you to take part in a research study on factors affecting employment of mental health consumers. I am doing this research in my doctoral program in Applied Psychology, at the University of Toronto.

The purpose of this research is to learn more about factors which help mental health consumers find and keep jobs. If you are a mental health consumer and you are working or you have left a job within the past six months, then you are most welcome to participate in this study.

If you decide to take part in this research you will be given three questionnaires to complete and a task involving rank ordering a set of statements on cards. You will also participate in an interview. I will go through the questionnaires with you and give you the choice of completing them with me or on your own. In the interview you will be asked to describe your experience of working and to share your views regarding the process of getting into the job market. The questionnaires will take approximately 45 minutes to complete and the interview will be similar in length. If you feel tired at any point you will be able to take breaks as you wish. We will meet at a time and place that are convenient to you.

There are no known risks involved in this research. Although there will be no immediate benefits, the information you and other participants provide will be very useful in the future. It will identify factors that may help other mental health consumers get back to work.

You are free not to take part in this study and you may withdraw at any time. If you choose not to answer any particular question(s) you will not be pressured in any way.

After you complete the questionnaires, I will collect them and keep them to examine. The interview will be tape-recorded so that I do not miss any important information. No names will be used when information from the tape is typed. The completed questionnaires, the tape, and all notes will be kept locked in a safe place and all identities will be confidential. Your name will not be used in any reports or publications that may result from this study.

If you are interested in taking part in this research please call me, Bonnie Kirsh, at 978-4647. Or, you can provide your name and phone number to the individual who provided you with this letter of information; he or she will pass your number on to me and I will contact you.
If you have any questions about this study, please do not hesitate to call me at 978-4647. Thank you for taking the time to read and consider this letter. If you are interested in participating, please respond within one week of receiving this letter. Thank you.

Sincerely,

Bonnie Kirsh, M.Ed., B.Sc.(O.T.)
APPENDIX II

Factors Affecting Work Integration for Mental Health Consumers

Consent Form

I, ____________________________________, have read the accompanying letter of information, have had the nature of the study explained to me and I agree to participate. I understand that I will be completing three questionnaires and a card ranking task as well as participating in an interview. I also understand that all information I provide will be kept completely confidential and that my name will not be used in reporting any results.

I know that I may choose not to answer any items and I may withdraw from the study at any time.

_________________________________________  __________________________
Signature                                   Date
APPENDIX III

Research Project:
Factors Affecting Work Integration for Mental Health Consumers

Please be assured that all information on this form will remain confidential.

Date: _________________________________________
Name: _________________________________________
Address: _________________________________________
Phone: _________________________________________
Age: ________________

Educational Level: (please include any vocational or training courses):
______________________________________________________________________________
______________________________________________________________________________

Are you currently employed?  □ YES  □ NO
□ Full-time  □ Part-time (hrs/week: _____)

If you are employed, please indicate your

Employer: _________________________________________
Job title: _________________________________________

Salary:  □ under $5,000/year
□ $5,000 - $9,000/year
□ $10,000 - $19,000/year
□ $20,000 - $29,000/year
□ $30,000 - $39,000/year
□ $40,000 - $49,000/year
□ $50,000 or above/year

B. Kirsh (1997)
Factors Affecting Work Integration

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Job Duties:

Please list jobs you have held and reasons for leaving.

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<th>Approximate dates</th>
<th>Employer</th>
<th>Job</th>
<th>Reason for Leaving</th>
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Have you been informed of a psychiatric diagnosis?  □ No  □ Yes

Please indicate diagnosis ________________________________

When did you first experience mental health problems? ____________________

B. Kirsh (1997)
Factors Affecting Work Integration
Approximately how many hospitalizations have you had for mental health problems? ____________________________________________________________

Approximate date of most recent hospitalization ____________________________

Length of most recent hospitalization ______________________________________

Have you had experience with any vocational programs for mental health consumers? (please specify):

_____________________________________________________________________

_____________________________________________________________________

Which mental health services are you currently using (eg psychiatrist, group program, social program, etc)? How frequently do you use these services?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Additional Comments:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

B. Kirsh (1997)
Factors Affecting Work Integration
Instructions: Below are several statements relating to one's perspective on life and with having to make decisions. Please circle the number above the response that is closest to how you feel about the statement. Indicate how you feel now. First impressions are usually best. Do not spend a lot of time on any one question. Please be honest with yourself so that your answers reflect your true feelings.

PLEASE ANSWER ALL QUESTIONS
BY CIRCLING THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL
PLEASE CIRCLE ONLY ONE

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<tr>
<td>1</td>
<td>Strongly Agree</td>
<td>2</td>
<td>Agree</td>
</tr>
<tr>
<td>3</td>
<td>Disagree</td>
<td>4</td>
<td>Strongly Disagree</td>
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1. I can pretty much determine what will happen in my life.

2. People are only limited by what they think is possible.

3. People have more power if they join together as a group.

4. Getting angry about something never helps.
5. I have a positive attitude toward myself.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

6. I am usually confident about the decisions I make.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

7. People have no right to get angry just because they don't like something.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

8. Most of the misfortunes in my life were due to bad luck.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

9. I see myself as a capable person.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

10. Making waves never gets you anywhere.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree
11. People working together can have an effect on their community.

1 Strongly Agree
2 Agree
3 Disagree
4 Strongly Disagree

12. I am often able to overcome barriers.

1 Strongly Agree
2 Agree
3 Disagree
4 Strongly Disagree

13. I am generally optimistic about the future.

1 Strongly Agree
2 Agree
3 Disagree
4 Strongly Disagree

14. When I make plans, I am almost certain to make them work.

1 Strongly Agree
2 Agree
3 Disagree
4 Strongly Disagree

15. Getting angry about something is often the first step toward changing it.

1 Strongly Agree
2 Agree
3 Disagree
4 Strongly Disagree

16. Usually I feel alone.

1 Strongly Agree
2 Agree
3 Disagree
4 Strongly Disagree
17. Experts are in the best position to decide what people should do or learn.

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<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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18. I am able to do things as well as most other people.

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<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
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19. I generally accomplish what I set out to do.

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<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

20. People should try to live their lives the way they want to.

<table>
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<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

21. You can't fight city hall.

<table>
<thead>
<tr>
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<th>2</th>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

22. I feel powerless most of the time.

<table>
<thead>
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<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>
23. When I am unsure about something, I usually go along with the rest of the group.

|---|------------------|---------|-------------|---------------------|

24. I feel I am a person of worth, at least on an equal basis with others.

|---|------------------|---------|-------------|---------------------|

25. People have the right to make their own decisions, even if they are bad ones.

|---|------------------|---------|-------------|---------------------|

26. I feel I have a number of good qualities.

|---|------------------|---------|-------------|---------------------|

27. Very often a problem can be solved by taking action.

|---|------------------|---------|-------------|---------------------|

28. Working with others in my community can help to change things for the better.

|---|------------------|---------|-------------|---------------------|
**APPENDIX V**

**WORKPLACE CLIMATE QUESTIONNAIRE**

Please check the appropriate box for each item.

<table>
<thead>
<tr>
<th></th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree Nor Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My concerns are listened to</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>My concerns are responded to</td>
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<tr>
<td>My ideas are asked for</td>
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<tr>
<td>When I do a good job it is acknowledged</td>
<td></td>
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</tr>
<tr>
<td>There is an emphasis on quality</td>
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<tr>
<td>I receive help in solving problems at work</td>
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<tr>
<td>I am treated with courtesy and respect</td>
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<tr>
<td>My contributions are valued</td>
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<tr>
<td>I am kept informed of changes that affect my job</td>
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<td>I am treated fairly</td>
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<td></td>
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<td>Work problems are resolved quickly and directly</td>
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<td>My coworkers are approachable</td>
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<td>My supervisor is approachable</td>
<td></td>
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<tr>
<td>Statement</td>
<td>Disagree</td>
<td>Somewhat Disagree</td>
<td>Neither Agree Nor Disagree</td>
<td>Somewhat Agree</td>
<td>Agree</td>
</tr>
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<td>----------</td>
<td>-------------------</td>
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<tr>
<td>I have a clear understanding of my job responsibilities</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The work environment is calm</td>
<td></td>
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<td></td>
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<tr>
<td>I have had good training for the job</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>I feel I am fairly paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to take holidays</td>
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<tr>
<td>I am able to adjust my working hours when needed</td>
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<tr>
<td>I am able to leave work for appointments</td>
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<td>Transportation to and from work is manageable</td>
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<tr>
<td>My health care benefits meet my needs</td>
<td></td>
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<tr>
<td>There is good potential for advancement</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I make some important decisions about the work</td>
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<tr>
<td>I have friends at work</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX VI

The Organizational Culture Profile
(O’Reilly, Chatman & Caldwell, 1991)

Organizational Profile Item Set

1. Flexibility
2. Adaptability
3. Stability
4. Predictability
5. Being Innovative
6. Being quick to take advantage of opportunities
7. A willingness to experiment
8. Risk taking
9. Being careful
10. Autonomy
11. Being analytical
12. Paying attention to detail
13. Being precise
14. Sharing information freely
15. Fairness
16. Respect for the individual’s right
17. Tolerance
18. Informality
19. Being easy going
20. Being calm
21. Being supportive
22. Being aggressive
23. Decisiveness
24. Taking initiative
25. Being demanding
26. Taking individual responsibility
27. Having high expectations for performance
28. Opportunities for professional growth
29. High pay for good performance
30. Low level of conflict
31. Confronting conflict directly
32. Developing friends at work
33. Fitting in
34. Working in collaboration with others
35. Enthusiasm for the job
36. Working long hours
37. Not having many rules
38. An emphasis on quality
39. Having a good reputation
40. Being socially responsible
41. Being competitive
42. Being organized
APPENDIX VII

Factors Affecting Work Integration of Mental Health Consumers

Guide for semistructured interview

1. **Meaning of work**
   a) How important would you say work is to you in your life?
   b) What has led you to think about work in this way?
   c) How has employment (change from employment to unemployment) affected your life?

2. **Personal Empowerment**
   a) Whose decision was it to work?
   b) Could you describe the choices and opportunities that you had (have)?
   c) Could you describe how you prepared (are preparing) yourself for the workplace?
   d) Do you feel there are things that you do well?
   e) Do other people say you do certain things well?
   f) What personal qualities helped (have helped) you find work?
   d) How satisfied are (were) you with your performance at work?
   g) How confident are you that you will continue working (find work)?

3. **Social Support**
   a) Who or what helped (has helped) you get back into the workforce?
      Probes: Who are these people?
      What services are they linked to?
   b) How were they helpful?
   c) Which of these were most helpful? Why?
d) What difficulties do you feel you needed (need) to overcome to become employed? How did you overcome these difficulties?

4. Workplace climate/culture
a) How satisfied are (were) you with your work situation?
b) What things detract(ed) from job satisfaction?
c) How could the job (have) become more satisfying?
d) Were any changes made to the job or the workplace so that it would be more manageable for you?

5. Other
a) What advice do you have for other mental health consumers who want to work?
b) Do you have advice for vocational counsellors and/or mental health workers?
c) Do you have advice for employers?
d) Is there anything else you’d like to tell me or ask me?
### TABLE 1
Factors derived from the WCQ (Workplace Climate Questionnaire)

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
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<th>4</th>
<th>5</th>
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<td>my concerns are</td>
<td>.479</td>
<td>.668</td>
<td>4.065E-02</td>
<td>8.689-02</td>
<td>-.120</td>
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<td>I am treated fairly</td>
<td>.787</td>
<td>.192</td>
<td>.134</td>
<td>.186</td>
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<td>work problems are resolved quickly &amp; directly</td>
<td>.622</td>
<td>.539</td>
<td>.174</td>
<td>5.801E-02</td>
<td>9.860E-04</td>
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<td>.265</td>
<td>.479</td>
<td>-.253</td>
<td>-.150</td>
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<td>-9.3E-02</td>
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<td>.113</td>
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<td>I am able to adjust my working hours</td>
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<td>.527</td>
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<td>.694</td>
<td>.173</td>
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<td>6.732E-03</td>
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<td>I have friends at work</td>
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<td>.612</td>
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<td>5.505E-03</td>
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<td>-3.1E-02</td>
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<td>7.651E-02</td>
<td>.151</td>
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<td>.223</td>
<td>.355</td>
<td>.116</td>
<td>6.580E-02</td>
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Extraction Method: Principal Axis Factoring
Rotation Method: Varimax with Kaiser Normalization
Criterion for loading = .400
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<tr>
<th>Variable</th>
<th>Employed n=17</th>
<th>Unemployed n=19</th>
<th>Total N=36</th>
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<tbody>
<tr>
<td>Age (in years)</td>
<td>42.4 ± 8.81</td>
<td>42.2 ± 6.88</td>
<td>42.3 ± 7.73</td>
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<tr>
<td></td>
<td>31-61</td>
<td>30-53</td>
<td>30-61</td>
</tr>
<tr>
<td>Number of Hospitalizations</td>
<td>6.4 ± 6.71</td>
<td>7.0 ± 7.70</td>
<td>6.7 ± 7.15</td>
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<td>1-20</td>
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### TABLE 3
Demographic Variables by Group

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<th>Employed (%) n=17</th>
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<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>M</td>
<td>58.8</td>
<td>47.4</td>
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<td>F</td>
<td>41.2</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>Partial high school</td>
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<tr>
<td>High school graduate</td>
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<td>5.3</td>
</tr>
<tr>
<td>Partial community college</td>
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<td>21.1</td>
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<tr>
<td>Community college graduate</td>
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<tr>
<td>Partial university</td>
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<tr>
<td>University degree</td>
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<td>26.3</td>
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<tr>
<td>Both community college &amp; university</td>
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<td><strong>Number of Jobs</strong></td>
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<td><strong>Length of Illness</strong></td>
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<td>68.4</td>
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<td><strong>Last hospitalization</strong></td>
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<td>31.3</td>
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<td>2-3 years prior to interview</td>
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<td>18.8</td>
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<td>longer than 3 years prior to interview</td>
<td>52.9</td>
<td>31.3</td>
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<td><strong>Length of last hospitalization</strong></td>
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<tr>
<td>less than 1 month</td>
<td>56.3</td>
<td>55.6</td>
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<td>1-2 months</td>
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<td>3-4 months</td>
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<td>longer than 4 months</td>
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<td>88.2</td>
<td>61.1</td>
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<tr>
<td>no</td>
<td>11.8</td>
<td>38.9</td>
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<tr>
<td>Mental Health Service</td>
<td>Employed (%)</td>
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<td>--------------------------------------------------</td>
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<td>crisis unit</td>
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<td>drop-in/social program/day program</td>
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<td>36.8</td>
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<td>15.8</td>
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<td>psychiatrist</td>
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<tr>
<td>self-help group</td>
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<td>10.5</td>
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<td>social worker, case manager or therapist</td>
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<td>31.6</td>
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<td>therapy group</td>
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<td>Scale</td>
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<td>Empowerment</td>
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**Correlation is significant at the 0.01 level**

Note: EMPQ (Empowerment Questionnaire); ISEL (Interpersonal Support Evaluation List); OCP (Organizational Culture Profile); WCQ (Workplace Climate Questionnaire).